Heathcotes Care Limited

Heathcotes (Erdington)

Inspection report

929 Chester Road
Erdington
Birmingham
West Midlands
B24 0HJ

Tel: 01213509790
Website: www.heathcotes.net

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

Summary of findings

Overall summary

About the service
Heathcotes (Erdington) is a residential care home providing personal care to two people at the time of the inspection. The service is able to support up to eight people from the ages of 13 to 65 years old.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence.

The service was a large home, bigger than most domestic style properties. There were no identifying signs to indicate it was a care home. Staff did not wear clothing which suggested they were care staff when going outside the home with people.

People's experience of using this service and what we found
The provider had not made all the necessary improvements since our previous inspection and people continued to be put at risk of unnecessary harm and abuse.

Although the culture at the home had improved since our previous inspection, there was further improvement needed to ensure people's safety and wellbeing was kept risk free.

People were not safeguarded against the risk of inappropriate restraint. Although people had clear support plans, risk assessments and guidance in place, these was not always followed. The provider did not monitor people's liquid medicines to ensure they had received them as required. Staffing levels were improved and people were supported by enough staff. The provider identified lessons to be learnt from incidents but improvement had not been made.

Staff did not always demonstrate respect towards people because some restraint was not necessary and they did not follow their individual guidance. However, during our inspection we did see caring interactions between staff and the two people who lived at the home.

Staff received the training they needed to support people, but this was not always put into practice. People's care plans were detailed, holistic and showed staff worked with other health professionals. People were supported to eat and drink enough.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. The provider had policies and systems in place, but the staff did not always support this practice.

The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people using the service reflected the principles of Registering the Right Support by promoting choice and independence, but not always control. People's support focused on them having opportunities and to become more independent.

People's care was planned around them as an individual. People's communication needs were assessed and staff knew how best to communicate with each person. The provider had a complaints process in place and most were dealt with at a local level.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 14 January 2020), and there were multiple breaches of regulation and the service was placed in special measures. At this inspection sufficient improvement had not been made and the provider was still in breach of regulations.

Following our last inspection, we imposed a condition on the provider's registration so they could not accept any new admissions to Heathcotes (Erdington).

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Enforcement
All representations and appeals have been concluded and we have imposed conditions onto the provider's registration in respect of the regulated activity, accommodation for persons who require nursing or personal care, at Heathcotes (Erdington).

Follow up
The overall rating for this service remains as 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under close review to check for significant improvements.

If the provider does not meet the conditions of their registration we will begin the process of preventing the provider from operating this service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our well-Led findings below.	**Requires Improvement**
Is the service responsive? the service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Heathcotes (Erdington)

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
This inspection was carried out by two inspectors

Service and service type
Heathcotes (Erdington) 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.

There was no registered manager in post at the home. The service is required to have a manager registered with the Care Quality Commission. This means that they 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 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. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three visitors and one relative. We spoke with eleven members of staff including care staff,

the acting manager, director of operations, quality auditor, regional manager and compliance manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included two people's care records and medication records. We looked at staff files in relation to recruitment, training and staff supervision. We also viewed a variety of records relating to the management of the service, including policies and procedures.

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.

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

At our last inspection the provider had failed to manage people's medicines safely and the systems in place did not keep people safe from the risk of harm. 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.

● The provider failed to ensure staff monitored one person's food intake effectively or provide sufficient guidance to staff. The person required staff to monitor and log their carbohydrate intake. This was because their medicine could affect their weight and they could overeat. The person's records stated staff were to be "mindful" of their carbohydrate intake, but did not state what "mindful" meant in terms of monitoring. Staff did not record the quantities of carbohydrates the person consumed. Managers could not provide evidence of any system in place which monitored or reviewed their carbohydrate intake. This placed the person at risk because the control measures in place did not ensure the risk was as low as reasonably possible.
● People had clear guidance in their care plans about risks. This gave staff detailed information on how they were to manage for example, their levels of anxiety, agitation or aggression. However, staff did not always follow these plans. Staff had followed one person into their room whilst they were agitated, yet their care plan stated for them to be given space once in their room. This increased the person's agitation and distress. This practice continued to put people and staff at risk of harm.
● The provider had failed to ensure decisions made about why physical restraint was used, were recorded. People's care plans clearly stated at least two staff members had to make the decision on which physical restraint technique to use. However, records of incidents did not have this information. The acting manager confirmed these decisions were not recorded but agreed they should be. This placed people at risk as the level of restraint may not be necessary and proportionate to the level of harm.
● The provider had not ensured staff completed incident reports and associated records in a consistent way. We had identified this concern at our previous inspection, and this continued to occur. We found three different accounts of one incident. Records were sometimes confusing and not clear on the events which had occurred, and some records were not fully completed. This placed people at risk because incidents could not be properly investigated to ensue staff practice aligned with best practice and lessons could be learnt.

People were not kept free from the 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.

● The two people who lived at the home were seen to be comfortable in their surroundings. One relative told us they had never felt their family member was unsafe whilst living at the home. This was because they felt they had a good relationship with staff.
● The provider had made improvement to the management of people's medicines. Improvement had been made to staff's administration of medicines and recording when people had refused their medicines.
● Since our previous inspection the majority of staff had completed their medicine safety course.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to protect people from harm and abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Since our previous inspection, we have continued to receive information about incidents where people have been put at risk of harm and abuse. People who lived at the home could display frustration, anxiety and distressed behaviour in a way which could cause harm to themselves, others or property. At times staff needed to use physical restraint to protect the person or others from harm. The provider had not ensured the use of restraint was always safe, proportionate or appropriate.
● People were put at risk of harm because staff did not always use the least restrictive measures when supporting people. Staff told us some staff went; "Straight to [physical] restraint, they just want to stop the behaviour. It's supposed to be a last resort." Managers confirmed staff continued to use restraint when it was not always appropriate. This was despite reminders at staff meetings and some reflective debriefs following the use of restraint. We had concerns about staff use of restraint at our previous inspection and this continued to happen. This placed people at the continued risk of inappropriate restraint and the physical and psychological harm this may cause.
● At our previous inspection, we had identified people were restrained in an unsafe way which did not reflect best practice or their individual guidelines. At this inspection, we saw managers at the home had identified this practice still continued, but had failed to take sufficient action to prevent this happening. Therefore, people continued to be placed at an ongoing risk of harm.
● Staff failed to follow people's care plans when identifying what actions to take in response to people's behaviour. Managers told us one person was known to react negatively to specific staff members. However, when one staff member was a known trigger to the person, they attempted to calm the person when they displayed distressed behaviour. This escalated the situation unnecessarily and resulted in injury to the person and staff member.
● The provider had not ensured people were protected against the risk of neglect. People who live at the home are required to have a specific number of staff supporting them throughout the day and night. Although managers deployed staff to meet these requirements, staff did not always ensure they provided this. One person had been left without staff supervision during an incident and staff did not always have line of sight to people's rooms when they were required to. The person was not harmed but staff had left the person at potential risk of harm. One person had not received medical attention following an incident when they sustained an injuries to their head. Staff records of the injuries were not clear or consistent and it was at least six hours before any medical advice was sought.

People were not kept safe from the risk of improper treatment. 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.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were sufficient, suitably trained staff deployed to ensure people's needs were safely met. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● At our previous inspection, the provider had failed to ensure there were enough staff to safely meet people's needs. At this inspection the skills mix of staff had improved as the number of people using the service had significantly reduced, and for the two people who lived at the home, there were enough staff on duty during our inspection to meet their needs.
● Two people lived at the home and the provider was able to keep the staffing levels at a safe number for them. However, despite sufficient staff in place, staff did not always meet their responsibility to ensure people were supervised in the way the person required to meet their needs.
● Staff continued to be recruited safely to the home.

Preventing and controlling infection
● The home was clean and staff demonstrated safe working practices in relation to infection control. Staff had received training on the control and prevention of infection.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff training was kept up to date. However, staff did not consistently use their training effectively when making decisions about the management of people's anxiety, distress or behaviour. Staff received training in safe working, safeguarding people, first aid, mental health and autism awareness and the safe use of physical restraint.
- The provider and managers had continued to recognise staff training was not always effective and had discussed concerns at staff meetings. Staff had been reminded physical intervention must always be a last resort and the least restrictive technique used. However, records confirmed the provider continued to identify staff used sometimes unnecessary restraint on people.
- Following our previous inspection, staff had been directed to view a video on restraint. However, the provider had not followed up on this to confirm if staff had watched this. One staff member told us they had not done this yet. The provider's systems for monitoring staff practice were not wholly effective.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

- Since our previous inspection five people had been moved to different services. At the time of this inspection, the local authority and other care providers were working with the provider and people's relatives to move the remaining two people to new services. People were being supported through a transition phase, ready for their move.
- Following our previous inspection, the provider had reviewed and updated people's care plans. The care plans we viewed contained information on people's physical, mental and social needs. Relatives were involved and information used from previous health professionals to create people's care and support plans. However, out of date information, for example one person's communication support plan, was not always removed from care records which made guidance unclear. This meant people's care and support may not be effective if staff follow out of date information.
- People had positive behaviour support plans in place. These help staff understand the reason for the behaviour, so they can better meet people's needs, enhance their quality of life and reduce the likelihood that the behaviour will happen. However, staff did not consistently apply the proactive strategies in place to prevent behaviour that challenges. Therefore, although best practice strategies and guidance were in place, these were not being used effectively.
- People had oral hygiene plans in place. These gave staff instruction on how to support people with their oral care, including what to do if the person showed dental pain.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to eat and drink what they wanted to. However, we found there was still no structure to menu planning despite this being a concern at our last inspection. One manager told us these were in the process of being written.

● Staff were flexible with mealtimes for people and they had access, with staff support to food and drink outside mealtimes. People were supported to choose their own food and staff were aware of their preferences regards food and drink. One staff member told us they encouraged one person to eat bananas because they knew they enjoyed them.

Adapting service, design, decoration to meet people's needs

● The environment met the needs of the people who lived there. The home was a large domestic style property, within a residential area and gave no indication of being a care home.

● People and relatives had access to several communal areas which they could use. Communal rooms continued to be sparsely furnished due to people's medical conditions and distressed behaviour, which could be directed at furnishings.

● At the time of our inspection, the interior of the home was being painted. We saw improvement to the general repair and decoration of the home since our last inspection.

Supporting people to live healthier lives, access healthcare services and support

● People had health action plans in place, but these were not always kept updated or completed fully. One person had a GP appointment cancelled nearly three weeks before our visit. The health action plan stated this needed to be rebooked but there was no follow up to this.

● People did have access, when they needed it, to local healthcare services such as their GP and community health services. They had health and wellbeing check-ups, which are in line with national guidance for people who have a learning disability.

Ensuring consent to care and treatment in line with law and guidance

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.

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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff offered choice to people and supported them to make their own day to day decisions, such as eating, drinking and how they wanted to spend their time.

● The provider followed the best interests principles appropriately when making decisions on people's behalf. People's relatives, healthcare professionals and staff were consulted when decisions needed to be made on people's behalf.

● The provider had systems in place to ensure the principles of the MCA and DoLS were followed.

Applications had been submitted to the local authority as required by law to deprive people of their liberty.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as inadequate. At this inspection this key question has improved to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

At our last inspection the provider had failed to ensure people were treated as equals and with the respect they deserved. This was a breach of regulation 10 (Dignity and respect) 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 10.

● Staff did not always show concern for people's wellbeing when they experienced emotional distress, agitation or anger. Staff did not always follow people's individual guidance to use redirection techniques, rather than restraint. Therefore, people did not always receive support in a caring or respectful way, which upheld their dignity.
● Staff did not show concern for one person's wellbeing during a recent incident. Despite staff having received training on how to respond to difficult situations, they had failed to ensure one person was safe. Although no harm came to this person, this demonstrated a lack of respect and compassion towards them.
● At our previous inspection, we had concern staff did not demonstrate respect towards the environment people lived in. People who lived at the home did not smoke, yet staff smoked in the home's back garden, in sight of people and did not clean up their cigarette butts. The provider had moved the area where staff smoked to another part of the back garden. We found staff still did not always use the ashtray provided. This showed a lack of respect towards people and the environment they lived in.

People were not always treated with respect. This is a continued breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● For the two people who lived at the home, we saw staff interaction had improved since our previous inspection. During our visit, we saw one staff member demonstrate a clear understanding of how to communicate and engage with one person. The person's method of communication was specific to them and the staff member engaged with them in a patient, effective and meaningful way.
● Throughout this inspection, staff demonstrated a caring approach to the two people who lived at the home. We saw positive interactions and engagement between staff and people. One relative told us they felt

there were, "Some really, really good members of staff."

● People were supported with their independence. One person was supported to make their own food and drink with staff support. Both people were supported to make their own choices on how they wanted to spend their time.

● We saw visitors to the home and relatives told us they were welcomed and could visit at any time. One relative told us their family member received, "Really good care from really good staff."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

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

At our last inspection the provider had not ensured people received care which was wholly person-centred. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

- Staff were seen to deliver person-centred care during our visit, but we continued to have some concern not all staff fully understood people's needs. This was because people were not always supported in line with their individual guidance.
- During our visit, we saw person-centred care being delivered to the two people who lived at the home. People chose what they wanted to do and staff supported this. It was clear some staff at the home understood people's needs and what made them happy.
- People's care and support plans were individual to them and their assessed needs. These were person-centred care and had been created in partnership with the person, as much as possible, their relatives and health professionals.
- People's care plans had been reviewed and updated since our previous inspection. They informed staff how to deliver care which was centred on the person as an individual. They contained information on what was important to the person, such as family relationships and interests, how they wanted to be supported and any identified goals.
- Because there were just two people living at the home, staff completed individual meetings with them. This was to discuss areas such as activities, food, what was working well or any concerns. These were completed by staff who they had good relationships with. Despite people's limited engagement and understanding, staff used their knowledge of the person to show their responses and involvement. This helped to involve people in their own care.

End of life care and support

- The provider had not identified or fully explored people's or their families wishes with regards to what they wanted to happen after their death. At our previous inspection, the provider had told us this was "ongoing". At this inspection we found no improvement.
- People who lived at the home were younger adults and so not expected to die whilst there. However, people may experience sudden death whilst living at the home, therefore they needed to ensure they had

wishes recorded.

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 relationships and complete the activities which interested and were important to them. We saw staff supported people to make decisions about what they wanted to do and how they wanted to spend their time. One relative told us staff made an effort for events such as birthdays, Halloween and Christmas.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The provider continued to meet the Accessible Information Standards.

● People had communication plans in place, which would inform staff if they needed to provide information in alternative formats. In their PIR, the provider told us, "We have easy read booklets, leaflets and policies available. Where the service may need to help an individual understand a specific topic or concern, we will endeavour to provide this information in a format that they understand. e.g. videos on health-related topics or easy read leaflets on bereavement."

Improving care quality in response to complaints or concerns

● People and relatives were provided with information about the complaints process when they first started using the service. Easy read and alternative format complaints procedure was available as needed.

● The provider had systems in place to record and investigate and to respond to any complaints raised with them.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to ensure their governance arrangements kept people safe. 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, despite there currently only two people living at the home and the provider was still in breach of regulation 17.

● Following our previous inspection, we took urgent enforcement action to prevent any new admissions to the home. The local authority had also taken action and moved people out of the home. Therefore, at the time of this inspection there were only two people who lived at the home. They were both moving to different services in the near future.
● The provider has a history of not achieving the required standards. This is the fourth consecutive inspection where a rating of good has not been achieved in well-led. The provider had not provided effective oversight and governance of the service's safety and quality to ensure all regulatory requirements were met.
● The provider's governance systems failed to ensure people's care records were complete. Audits had failed to identify people's care records continued to not always have dates on them so the currency of the information could be established. People's and staff names were often recorded as initials or not recorded at all, therefore they could not be identified easily and kept confidential to that person. The provider's audit systems had failed to identify these concerns were still occurring so remedial action could be taken.
● The provider's audits had failed to identify one person's dosages of medicines had been recorded incorrectly in their health action plan. This is information which would accompany the person if they had to be admitted to hospital, so the hospital staff would know what care the person needed. Staff had incorrectly used millilitres (mls) and milligrams (mgs). The impact of this on the person's health could be significant if staff administered incorrect doses.
● The provider's quality systems continued to identify staff did not complete incident, restraint and daily records in enough detail. Staff completion of care records was still inconsistent and did not always have enough clarity or detail of actions taken. The provider had addressed this with staff at team meetings in October and November 2019, yet this continued to happen. Therefore, the provider's systems to monitor the service provided were ineffective because, whilst identifying errors, insufficient steps had been put in place

to affect change.
● The provider's systems were not effective enough to implement and monitor the required changes within the service. We had raised concern about the use of restraint at our previous inspection. Since then, managers had continued to identify issues with staff use of restraint. This had not been addressed in a timely manner and continued to happen. The acting manager told us staff were putting themselves in situations where they had to react, therefore unnecessary restraint had been used. This was due to them not correctly following people's positive behaviour support plans.
● The provider's systems to monitor the service and drive improvement were not effective. For example, where the provider had investigated incidents, the learning from these had not been used to drive improvement. Therefore, poor practice continued to be repeated.
● The provider had made some improvement to the culture at the home and following our previous inspection a number of staff had been dismissed. However, we still had concern the culture at the home did not fully respect people's rights and keep them safe at all times.
● The provider's monitoring systems had not been effective to ensure staff always followed peoples' care plans. Systems to monitor staff practice had failed to address staff were not consistently applying their learning into practice. This prevented a culture which was fully person-centred.
● We had concerns the historical lack of stable management had impacted on staff practice and culture. There has been no registered manager in post at the home since May 2018. Since our previous inspection, three separate managers had been in post at the home. Therefore, there has not been any consistent oversight from one manager. The current acting manager, had only been in post for two weeks prior to our inspection.

People's health, safety and welfare continued to be put at risk because quality systems had not driven the improvement needed. This is a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People who lived at the home had limited verbal communication and understanding. Their relatives acted as a point of contact and one told us they felt involved in and kept updated on everything which affected their family member. They told us they had opportunities to give their feedback and opinion on the service through talking with staff and managers.
● Staff told us they felt supported and understood what was happening at the service. They had been involved at staff meetings to give their ideas for how improvements could be achieved.
● The acting manager told us since they had started two weeks earlier, their focus had been looking at the staff team, the quality of the service and giving staff guidance. They said, "We have experienced staff and new staff and I'm making sure they're following the correct systems and have someone to go to for guidance." They knew improvement was needed but had not been at the home long enough to affect change.
● The provider continued to work with other healthcare professionals to benefit people. Staff worked with community learning disability teams and the local authorities who funded people's care. This helped support people's care provision and their transition to new care providers.

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 provider and managers understood their responsibilities under duty of candour. The duty of candour requires registered persons to act in an open and transparent way with people in relation to the care and treatment they receive.

● The provider had ensured the homes previous inspection rating was displayed at the home and on their website. This is required by law.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

The enforcement action we took:

We imposed conditions onto the provider's registration in respect of the regulated activity accommodation for persons who require nursing or personal care at Heathcotes (Erdington).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to keep people safe and people continued to be put at risk of unnecessary harm and abuse.

The enforcement action we took:

We imposed conditions onto the provider's registration in respect of the regulated activity accommodation for persons who require nursing or personal care at Heathcotes (Erdington).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured people were safeguarded against the risk of inappropriate restraint.

The enforcement action we took:

We imposed conditions onto the provider's registration in respect of the regulated activity accommodation for persons who require nursing or personal care at Heathcotes (Erdington).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had policies and systems in place but had not ensured all staff followed these, which placed people at risk of having their health, safety

and wellbeing put at risk.

The enforcement action we took:

We imposed conditions onto the provider's registration in respect of the regulated activity accommodation for persons who require nursing or personal care at Heathcotes (Erdington).