Heathcotes Care Limited

Heathcotes (Wakefield)

Inspection report

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03 December 2020

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Heathcotes Wakefield is a residential care home providing personal care to 18 people at the time of the inspection. The service can support up to 20 adults with learning disabilities and complex needs.

Heathcotes Wakefield supports people in two single storey houses and a building containing three flats, on shared grounds.

People's experience of using this service and what we found
Staff deployment to meet people's needs was not clearly demonstrated, particularly where some people required 2:1 support, or when staff had been deployed from other parts of the service.

Individual risks to people were clearly documented in their support plans and staff were confident in their understanding of these. However, some other risks were not well assessed or managed thoroughly to ensure people's safety, such as kitchen refurbishment work taking place and the risk of infection from COVID-19.

Many infection prevention and control measures were in place and known by staff, with regular daily regimes including cleaning and health monitoring. However, personal protective equipment was not always worn correctly to prevent the spread of infection.

Safety related training for positive behaviour support and medicines had not been robustly carried out in line with the organisation's policy. The management team told us this was as a result of training restrictions during the COVID-19 pandemic. Staff reported a lack of confidence in dealing with behaviour that challenged them.

Medicines were managed safely overall, with clear daily recording. People were supported individually to receive their medicine and procedures were clear.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always align with the practice. Positive behaviour support plans were in place, although these were not consistently adhered to and there was a lack of robust debriefing or management scrutiny of incidents where restraint had occurred.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of

Right support, right care, right culture.

Right support:
• Model of care and setting did not always maximise people's choice, control and independence. People accessed the community only when staff deployment enabled this.

Right care:
• Care was not always person-centred and did not consistently promote people's dignity, privacy and human rights. Staff interacted with people in positive ways, although spoke about people rather than with them at times. Some interaction did not fully consider people's rights.

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff had not always ensured people using services led confident, inclusive and empowered lives. The new manager was working closely with senior managers and support staff to improve the culture in the service.

The service had recently experienced changes in the management and there had been some emerging concerns which had not been identified through the routine quality assurance processes. The provider was swift to act upon concerns and was working hard to address issues raised through safeguarding and the inspection process.

We made recommendations in relation to staff skills, interaction and deployment which impacts upon their ability to provide person-centred care, and closer management scrutiny of risks and incidents.

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 Good (published 22 May 2018).

Why we inspected
We received concerns in relation to inappropriate use of power and misuse of restraint, poor management and poor staffing culture. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.
You can see what action we have asked the provider to take at the end of this full report.

We have found evidence that the provider needs to make improvements. Please see the key questions sections of this full report.

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 arusing 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 discharge our regulatroy functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identfied breaches in relation to keeping people safe from the risk of infection and providing care which meets people's individual needs and preferences. Please see the action we have told the provider to take at the end of this report.

We found no evidence during this inspection that people were at risk of harm from this concern. Please see the key questions sections of this full report.

Since concerns were identified and discussed with the provider, there had been closer scrutiny and monitoring of quality in the service, with a change of manager and additional presence of the senior management team.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heathcotes Wakefield on our website at www.cqc.org.uk.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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?

Requires Improvement

The service was not always 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 (Wakefield)

Detailed findings

Background to this inspection

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

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

Inspection team
There were two inspectors.

Service and service type
Heathcotes Wakefield is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission, but they were no longer in post. There was an acting manager who told us they intended to apply for registration. Having a registered manager 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.

Inspection activity started on 30 October 2020 and ended on 8 December 2020. We visited the premises on 30 October 2020, 18 November 2020 and 25 November 2020. We telephoned the service a few minutes before our entry on each occasion, to check the risks in relation to COVID-19.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as alleged abuse or when a person injures themselves. We contacted relevant agencies such as the local authority and safeguarding teams. We used all this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. 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. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with the acting manager, the regional manager and the head of services manager. We reviewed three people's care records, people's medicines records and staff recruitment records.

In between our visits to the service, we reviewed documentation sent to us by the provider. We spoke on the telephone with 10 staff, four relatives, two people's advocates and other professionals involved in people's care.

After the inspection
We asked the provider to send documentation to support the improvements made and demonstrate further how the service was run. On 3 December 2020 we spoke by telephone with the head of services manager to clarify information received. We used the time in between visits and until the 8 December 2020 to review all of the information sent to us.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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.

Staffing and recruitment

● Staff deployment to meet people's individual needs was not clearly demonstrated. Staff rotas did not accurately show which staff supported which people, and records inaccurately showed staff supporting several people at the same time.

● Staff from other parts of the service worked between locations but it was not always clear when or why this was. During the first day of inspection, one member of staff arrived from another of the provider's homes but did not know why they had been asked to come or who they were there to support. During the second inspection visit, a member of staff had been asked to leave the Agbrigg house to support the Sandal house upon arrival of the inspector. Staff reported a lack of staffing in the service, particularly when people wanted to be supported with going into the community.

● Not all staff had completed recent practical safety related training, such as positive behaviour support, in line with the provider's policy. The provider told us this was due to restrictions in training delivery as a result of the COVID-19 pandemic. As a consequence, staff were not confident when supporting people with behaviour which challenged them and some staff said they felt frightened at times.

We recommend the provider considers ways in which staff deployment demonstrates people have the right level of support and improve staff's confidence and competence in working with behaviour which challenges them.

● Recruitment systems were in place and followed to ensure staff were suitable before working with people. Staff newly recruited told us they had been given opportunities to shadow and observe more experienced staff before working independently.

Systems and processes to safeguard people from the risk of abuse

● Staff understood the safeguarding procedures in place and how to report concerns. People felt safely supported. The management team told us they encouraged staff to speak out if they had any concerns about practice in the home. However, not all staff felt confident to approach the management team with concerns.

● Systems and processes were not always robust enough to ensure restrictive physical interventions were only carried out as a last resort when responding to behaviours which challenged. There was a clear policy in place and staff understood the principles of positive behaviour support. However, they did not all understand the triggers or de-escalation techniques when working with individuals. This meant at times incidents were not always managed in line with people's assessed needs. Where staff had used restraint, there was limited management scrutiny of the incidents and debriefs were not consistent or thorough

enough to identify lessons learned.

We recommend debriefs are consistently carried out in line with good practice guidelines, with closer management oversight to minimise the use of restraint.

Assessing risk, safety monitoring and management
● Individual risks were documented in people's support plans and staff understood these and how they impacted upon people's care. However, risks within the service were not always identified, assessed or mitigated. For example, on the third day of the inspection we saw the kitchen in the Sandal house was being refurbished and there were contractors on site. The contents of the kitchen had been removed into the adjacent dining room and were being stored all around the room. The acting manager had arranged for a lock to be placed on the dining room door to minimise people's access, although there had been no assessment of risk or impact upon individual people caused by the disruption.

Preventing and controlling infection
● We were not assured that the provider was using personal protective equipment effectively and safely. During the first day of the inspection, staff did not follow correct procedures for wearing face masks and repeatedly touched and adjusted masks during our visit. Some staff went outside for a short break and placed their mask under their chin before returning to the building and replacing it. During the third visit, some staff were not wearing their masks appropriately in one of the houses, although immediately did so upon our arrival.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Staff told us they had been deployed from one house where people had been COVID-19 positive and were self-isolating, to another house where there had been no positive cases.
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Visitors had their temperatures taken on arrival and there was a COVID-19 symptom declaration completed by all visitors.
● We were somewhat assured the provider was meeting shielding and social distancing rules. Staff told us they had been reminded of the policy around this and tried to ensure safe practice wherever practicable. Due to the nature of people's support needs it was not always possible to ensure social distancing.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. Regular cleaning regimes were in place.
● We were assured that the provider's infection prevention and control policy was up to date.

Due to robust infection prevention and control procedures not being followed, people were at 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.

Using medicines safely
● People received their medicines when they needed them. Staff were patient and supported people individually.
● Systems and processes for ensuring safe management of medicines were mostly in place. Not all staff had received medicines training, although this had been identified by the provider's quality audits and action was being taken to improve staff training.

Learning lessons when things go wrong
● The management team were keen to ensure any disruption caused by the changes to the registered

manager were kept to a minimum. They had carried out an internal investigation once they were aware of concerns and they had commenced work to stabilise the management of the service and improve the culture in the home.

● There were missed opportunities to identify where lessons could be learned from incidents where people's behaviour had challenged staff. Staff identified concerns on some incident reports but 'N/A' was noted rather than details of action taken.

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 Good. At this inspection this key question has now deteriorated to Requires Improvement. 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

- It was not always clear how people's needs were consistently supported in a person-centred way. Staff did not all demonstrate confidence or an understanding of the needs of autistic people, particularly where there were behaviours which challenged staff. Although positive behaviour support plans were detailed and person-centred, staff were not always able to describe proactive or re-directive strategies used to support individuals in a positive way, as an alternative to physical intervention.
- Staff supported people according to their availability; where some people needed 2:1 support this was facilitated according to when and whether staff were available, rather than based upon people's preferences.
- Some staff told us care was not always person-centred because there were not always enough staff to be able to take people out when they wanted, and some people did not have their full amount of 2:1 support. Records did not evidence people had the amount of 2:1 support they were entitled to, which meant their choices and autonomy may be limited.

We found no evidence people had been harmed, however, systems were not robust enough to ensure care was designed to meet people's individual needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People said they were happy living at Heathcotes. One person said, "I have friends here, the staff are nice" and another person said, "It's alright here, I wanted to leave but now I don't, I'm happy."
- Daily notes and records of people's individual care and support were person centred on the whole, outlining their goals, choices and positive risk-taking plans. Staff signed to say they had read and understood people's care and support plans.

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.

- Staff spoke with people in supportive ways at times to discuss their needs and preferences, but this was not consistent. For example, staff gave people choices and respected their responses, but in contrast, staff spoke with one another about a person in their presence and discussed plans for activities without including the person. On occasion, we heard staff speak with a person in ways which were not supportive, such as with sarcastic or paternalistic tones.

We recommend the provider assesses interaction between staff and people who use the service to ensure communication is meaningful and inclusive.

● Staff understood people's individual sensory needs and abilities and ensured information was communicated in ways people could understand. Staff used simple gestures and signs to support people's communication. Where one person had limited vision, staff guided them verbally whilst promoting their independence.
● Pictures, photographs and easy-read documentation was available to support people to understand information, such as in their support plans.

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
● Staff understood what individual people were interested in and who was important to them. People's preferred activities outside the home had been affected by the COVID-19 pandemic and this had caused some upset due to unsettled routines. Staff said they had tried very hard to ensure people had as much of their familiar routines as possible, in spite of the restrictions.
● Staff had facilitated garden visits from people's relatives in line with the guidelines for the COVID-19 restrictions and relatives commented positively about this.
● Most relatives we spoke with were complimentary about way the service had involved them and kept them informed about important matters. However, not all relatives felt the service was able to meet their family members' needs.

Improving care quality in response to complaints or concerns
● The service had not received any formal complaints since the change of management. The management team said they were open and responsive to complaints and concerns and would use these as an opportunity for further improvement.
● Relatives said they would bring any concerns to the managers or the staff, but not all relatives were confident any complaints or concerns would be acted upon.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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.

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

- The key values and vision for the service were documented in corporate information, but were not known or promoted by staff at any level, or embedded throughout the service.
- There were mixed views about the culture in the home. Some staff felt supported, whilst other staff reported 'cliques' and a lack of open-ness and trust in the management team.
- The manager was beginning to address the concerns around poor culture in the home and was implementing new ways of working to encourage more open communication.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 manager was new to the service, although had previous knowledge and experience of this location and the provider's other locations. Staff had felt unsettled due to some recent changes to management and different management approaches. Many staff reported feeling much clearer about their roles and responsibilities since the new manager had taken up post and was beginning to instil confidence.
- There was a contrasting atmosphere between the way the two houses were managed. Some staff reported a lack of consistent leadership in the Agbrigg house. The manager was transitioning to work at the service and was part time, focusing on quality issues in the Sandal house, although this meant there was less oversight of the service as a whole.
- The manager received ongoing support from senior managers, who helped to facilitate quality checks and improve the way in which the service was run. Quality audits were carried out, although needed to be improved to help better understand the culture in the whole service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Some relatives and people's advocates told us they felt involved and informed. They were aware there had been changes to the management of the service and they knew who to contact with any queries or communication.
- There was no evidence of any discrimination in the service; policies and procedures acknowledged people's rights and quality characteristics were considered and respected.
- There were mixed views amongst the staff regarding their engagement in the service; some staff said they

felt there was a lack of communication with senior managers and they did not feel valued for their contribution to the work, or listened to. Other staff felt well supported in their roles, although formal supervisions had not consistently taken place.

● Other professionals reported communication with the management at the service had not always been effective, although there had been recent improvements in this.

Continuous learning and improving care

● The management team had identified areas to improve and were working to address any shortfalls in quality and embed new ways of working. They had been prompt in their response to information requested as part of the inspection. Audits were being developed further and the format of these was being improved.

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 9 HSCA RA Regulations 2014 Person-centred care People's care was not always personalised to ensure their individual needs were met and not all staff were confident in meeting individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not robustly in place to prevent the spread of infection in relation to the COVID-19 pandemic.