Heathcotes Care Limited

Heathcotes Enright Lodge

Inspection report

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Date of inspection visit:
14 April 2021

Date of publication:
09 August 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Heathcotes Enright Lodge is a residential service that can accommodate up to six people. The service accommodates four people in one shared bungalow and two other people in self-contained apartments. The service specialises in caring for people with learning disabilities, autism spectrum disorders and complex mental health needs. At the time of the inspection one person was living at the service.

Within the same grounds the provider had a second registered location Heathcotes Enright View that provided the same service and could accommodate seven people.

People's experience of using this service and what we found
Staff had received training in safeguarding, however, did not always recognise issues that should be identified and reported.

People's needs were assessed, and support plans were in place, however they were not always up to date and there were inconsistencies in how staff applied support to people.

Staff did not always have the right mix of skills, competence and experience to support people. Staffing levels were still impacted by a high turnover of staff.

Staff recruitment procedures were in place and staff had a probation period with training and shadow opportunities. Staff had mandatory training in place, however, staff did not always have 'service user specific training' in place before they commenced worked under supervision.

Incidents did not always have effective measures in place to avoid reoccurrence.

The service was clean and well maintained. Staff were following current guidelines for infection prevention and control.

Medicines were stored, administered and disposed of safely.

There was a registered manager in post who was responsible for running another service on the same site, with overview of Enright Lodge. The service had a manager who had been in post for six months and improvements within the service had not been fully sustained. Staff reported inconsistencies in team working and support from management.

Systems and processes to monitor the quality of the service were in place and were identifying and addressing concerns to learn and make improvements.

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 statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not always able to demonstrate some of the underpinning principles of Right support, right care, right culture. Some practice we identified was restrictive and reduced people's choice. This was recognised by the service, reported and measures put in place to improve practice.

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

Rating at last inspection
The last rating for this service was requires improvement (published 13 September 2019).

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels, staff training and supervision. A decision was made for us to inspect and examine those risks, and we undertook a focused inspection in Safe and Well-led only.

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.

The overall rating for service has remained at Requires Improvement. This is based on the findings at this inspection.

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

Follow up
We will continue to monitor information we receive about the service until we 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 well-led?

Requires Improvement

The service was not always Well-Led.

Details are in our Well-Led findings below.

Heathcotes Enright Lodge

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
The team consisted of two inspectors onsite, a specialist learning disability nurse onsite, and an inspector offsite who made phone calls to staff. We also used an Expert by Experience, who is a person who has personal experience of using or caring for someone who uses this type of care service to phone families of people living at the service.

Service and service type
Enright Lodge 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.

Heathcotes Enright Lodge was developed in response to the national 'Transforming Care' agenda, which aims to improve health and social care services so that more people with a learning disability can live in the community.

The service had 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
We gave the service 24 hours' notice of the inspection. This was because the service is small, and people are

often out, and we wanted to be sure there would be people at home to speak with us.

What we did before inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. 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 took this into account when we inspected the service and made the judgements in this report.

During the inspection-
We spoke with one person who used the service and one relative about their experience of the care provided. We spoke with seven members of staff including the manager, team leaders and support workers.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures and quality assurance inspections and action plans. We spoke with two health care professionals who worked with the service.

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 Requires Improvement. At this inspection this key question has remained the same. 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.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from improper treatment. Staff had training in safeguarding, however they did not always recognise incidents that may need reporting.
- On reviewing support plans, we identified a repeated incident that had occurred where staff had not acted in a consistent or appropriate way which subjected the person to punitive practice.
- We discussed this with the management team as the issue had not been identified and strategies had not been put in place swiftly enough to support the person appropriately. The management team immediately amended the support plan and reported the incident to the safeguarding team.

The failure to protected people from the risk of abuse is a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks in relation to people's care and support were not always managed safely. Risk assessments were in place, however support plans were not always reviewed and updated when needs or behaviour changed. We found inconsistencies in the way one person was supported when asking to access an area of their home which resulted in unnecessary restriction being placed on the person.
- Not all staff on shift were trained to the required level, to safely support the person if physical intervention was needed. This posed a risk of injury to the person or staff.
- Staff told us that the team leaders worked in different ways, "It is confusing for us and the person who lives here". This combined with a delay in updating support plans sometimes led to inconsistent care. The management team told us they were aware and had organised meetings to identify and resolve differences within the teams and increase staff support.
- Staff reported they did not always feel safe or supported by each other or the management team. We raised this with the management team, who were aware of staff feelings following recent staff surveys and meetings and had put extra support in place to address this.
- The environment was well maintained and there were regular checks of environmental health and safety concerns. A relative we spoke with told us they thought their family member was safe. They said, "The staff and the environment make it safe. [Name] is very settled here after living at lots of other places, staff go the extra mile".

Staffing and recruitment

- Issues with staff retention and staff turnover were ongoing. Staff told us there were not always enough staff who were skilled to deal with the complexities of people living at the service, which impacted on the

support they gave.
● Staff told us that they worked in three teams, however there was a lack of consistency across the teams. This combined with the high turnover of staff impacted on the continuity of support.
● Healthcare professionals we spoke with, also told us staff turnover was high and they did not think staff always had sufficient skills and training to support people. A relative said, "There are usually enough staff, when they start they get trained up".
● Due to complex behaviour, most staff at the service were trained in how to use a higher level of physical restraint to support people in extreme circumstances when they put themselves or others at immediate risk of harm. However, it was not clear from the staffing rota that enough staff were trained in the use of restraint techniques to ensure there were a sufficient number of fully trained staff available each shift at Enright Lodge. It was not clear that staff had full training in place before they started supporting people.
● Appropriate pre-employment checks had been carried out on new staff members to make sure they were safe and suitable to work at the service.

Learning lessons when things go wrong
● Opportunities to learn from accident and incidents had been missed. There had been several recent incidents and it was not clear that lessons had been learnt to prevent these happening again as several incidents were of a similar theme.
● Although there was analysis of incidents that occurred and debriefing sessions for staff, staff told us they did not always know how to offer support, and this had not improved. The manager did not have the higher level of training in restraint so did not have the training to competently review and analyse incidents that used this sort of restraint.
● The management team told us they were aware of staffing issues and staff not feeling supported and had recently put in further measures to improve staff stability by increasing staff support around incidents to increase learning and build confidence.
● Staff told us debrief sessions after events helped, but some staff reported despite this, they still did not always feel confident in dealing with behaviours that challenge due to poor support from the management team

The failure to provide consistently safe care and treatment, maintain up to date support plans and learn lessons from incidents put people at risk of harm. Failure to ensure suitably qualified and skilled numbers of staff put people at risk of harm. This is 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 safely. Storage, administration and recording of medicines was safe.
● Only senior staff administered medicines following training and competency assessments and we observed people being given their medicines safely.
● Any medicines errors were actioned immediately to ensure the persons safety and were then reported and investigated appropriately with training needs identified and lessons learnt or disciplinary action if appropriate.
● The service had policies and procedures in place to support staff knowledge.
● To support people's independence, there were self-medication assessments in people's records with information as to why, or why they were not able to self-medicate.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● 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.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Several staff told us that the manager did not have higher-level training in restraint and there were not always enough trained staff in place to support with incidents. As a result, they did not always feel safe at work. The manager used alternative techniques to manage behaviour that challenged, which staff felt undermined the support they gave.
- Staff feedback raised themes of feeling unsupported by the manager, with inconsistencies in the way teams worked and the way staff approach support. Staff also told us that communication was not always good and they felt the handover was not always detailed enough after days off.
- A review of incidents and accidents took place, however it was not always clear how effective this was to show improving care, as we identified themes of incidents that had reoccurred. After incidents, team leaders organised de-briefing sessions to support staff. Most staff reported they found this helpful, however some reported they did not feel comfortable raising concerns in this environment.
- Systems and processes to monitor the quality of the service were in place and the management team had already identified most of the concerns we raised. Audits in place identified areas for improvement on a weekly basis so improvement could be made quickly. However, concerns around staff turnover, staff training levels, inconsistent care and staff feeling unsure how to support the service user effectively had still not been fully addressed by the management team.

The service was poorly managed, this resulted in inconsistent care and support for people and a lack of learning lessons when things went wrong. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- There was a registered manager at the service who had oversight of the service and took responsibility for meetings, placements of people and incidents and accidents. They did not spend the majority of their time at Enright Lodge as they also managed the service next door.
- There was a manager at the home who had been in post for 6 months and was responsible for the daily running of the service and was in the process or registering with CQC.
- Staff meetings were used to identify training needs and supervision staff required. Staff told us they received supervision which they told us was helpful.
- We saw evidence at one meeting where the quality of incident forms had been reviewed and staff were requested to write in a more factual way rather than from a personal view of the incident to improve

standards of recording.

Working in partnership with others
● We spoke to an external healthcare professional who told us that they had tried to support staff training, but due to poor communication and high staff turnover it had been difficult to upskill staff.
● The manager worked with several different health care professionals to support people living at the service. During our visit the management team implemented a professional feedback communication sheet to ensure clear documentation of actions taken were recorded.
● The manager told us they would continue to engage with external agencies to provide staff with training and strategies to support people living at the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We received feedback that the manager did not always work in line with care plan guidance and the manager told us they had their own way of doing things that worked. The manager had not shared these ways of working with the team and there was a risk this may have disempowered the person and led to dependency. The management team were aware of staff concerns and had put measures in place to support the manager.
● Staff told us they had been visiting a person who was expected to be admitted to the service. The manager told us they had been training staff and arranging visits to ensure a smooth transition from one service to another. However – we found out that due consideration had not been given to compatibility of people living at the service, which could have compromised the safety and quality of care.
● The provider had not ensured all staff had the required training to enable them to provide high quality, safe care. The manager and some staff did not have an adequate level of training to support a person safely if their behaviours escalated to a point where they placed themselves and others at risk of harm.
● Staff supported people to build independence by supporting them with activities of daily living. One person told us, "I like to go out in the car, yesterday we went out for ice creams. A relative told us "[Name] goes out shopping and for walks, staff help them to do the laundry and clean their flat".
● We saw the person had received certificates of achievement when they had had to be patient whilst waiting in a shop, which supported positive behaviour.
● A relative told us, "I am invited in for meetings to be involved in the support plan, so I know when things change".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The service engaged with staff, relatives and service users via surveys in order to obtain their views. We saw the results of the most recent surveys which were still being analysed.
● The service used easy read and Makaton, which consists of signs, speech and symbols to aid people's understanding. Staff told us that [Name] sometimes found it easier to talk with them using a walkie-talkie rather than face to face.
● The manager organised staff meetings to give staff the opportunity to discuss issues. They told us they had recently consulted with staff about taking regular breaks and had implemented a daily staff rotation plan to support staff having breaks.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager overseeing the service was aware of their legal responsibilities to be open and honest.

● A relative we spoke to told us they phoned regularly and were kept up to date with what was happening, "[Name] had a sore throat and they told me straight away, when there was a medicines error they explained to me what had happened".

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 12 HSCA RA Regulations 2014 Safe care and treatment Failure to maintain up to date support plans and learn lessons from incidents put people at risk of harm. Failure to ensure suitable qualified and skilled numbers of staff put people at risk of harm.

The enforcement action we took:

Vary a condition

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 People were not always protected from the risk of abuse as incidents were not always recognised and reported.

The enforcement action we took:

Vary a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was poorly managed, this resulted in inconsistent care and support for people and a lack of learning lessons when things went wrong.

The enforcement action we took:

Vary a condition.