Heathcotes Care Limited

Heathcotes (Moorgreen)

Inspection report

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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

We conducted an unannounced inspection at Heathcotes (Moorgreen) on 23 and 25 October 2018. Heathcotes (Moorgreen) 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 (Moorgreen) provides short term treatment, support and accommodation for up to eight people who have a diagnosis of personality disorder. On the day of our inspection, six people were using the service.

We carried out an unannounced comprehensive inspection of this service in March 2018. Two breaches of legal requirements were found in relation to; risk management and staff recruitment. The service was rated as Requires Improvement.

Since our March 2018 inspection we received concerns in relation to the safety of care provided at Heathcotes (Moorgreen). As a result, we undertook this focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heathcotes (Moorgreen) on our website at www.cqc.org.uk. This is the third time this service has been rated as requires improvement.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our inspection we found the service was not consistently safe. People told us they sometimes felt safe at Heathcotes (Moorgreen), this depended on the behaviour of others. Referrals had not always been made to the local authority safeguarding adults team, this meant there was a risk safeguarding incidents may not be appropriately investigated. The local authority safeguarding adults team had recently investigated several concerns and found evidence of neglect of people's health needs. Staff did not always have sufficient training to ensure people were safely supported with behaviours that could place them or others at risk. There were systems in place to learn from accidents and incidents; however, actions taken to reduce the risk of repeat events were not always clearly recorded.

In contrast, in other areas we found staff had a good knowledge of how to manage risks associated with people's care and support. Further work was needed to ensure people were protected from the risk of Legionella. Other environmental risks were managed safely. There were enough staff available to meet people's needs and ensure their safety. Since our March 2018 inspection improvements had been made to ensure safe recruitment practices were followed. Overall medicines were managed safely and records showed people received their medicines as prescribed. Good hygiene practices were followed and overall the environment was clean and hygienic.

Heathcotes (Moorgreen) was not consistently well led. Auditing systems were not fully effective in addressing areas for development because actions planned to address areas of concern had not always been completed. Records of people's care and support were not always accurate and up to date. In addition, incident records had not always been fully completed to show what action had been taken in response to adverse events. We found staff did not all have sufficient knowledge or training to enable the provider to deliver the specialist aspects of the service. The provider had not notified us of all significant incidents in the home, as required by law. Feedback about the registered manager was positive from both people living at the home and staff. People were involved in the running of the home and their feedback was encouraged and acted upon. Staff felt supported and were also involved in the running of the home.

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

People were not adequately protected from risks associated with their care and support. Improvements were needed to ensure learning from accidents and incidents was clearly documented. There was a risk safeguarding incidents may not be appropriately investigated as referrals were not always made to the local authority safeguarding adults team. Overall, people's medicines were managed safely. There were enough staff to meet people's needs and ensure their safety. Safe recruitment practices were followed. The home was clean and hygienic throughout and infection control procedures were followed.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality assurance systems were not always effective in ensuring action was taken to address issues. Records of people's care and support were not always accurate and up to date and other records were incomplete. Further work was required to ensure staff had the knowledge and skills to deliver the specialist aspects of the service. People living at the home had opportunities to express their views about how the service was run. Staff felt supported and were given opportunities to makes suggestions to improve the running of the home.

Heathcotes (Moorgreen)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to consider concerns we received in relation to the safe management of people's behaviours and access to medical care at Heathcotes (Moorgreen).

The team inspected the service against two of the five questions we ask about services: 'is the service Safe' and 'is the service Well Led.' This is because we received concerns in these areas.
No further risks, concerns or significant improvements were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Before our inspection visit, we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events, which the provider is required to send us by law, such as, allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

Three inspectors undertook this unannounced inspection. Three visited on 23 October 2018 and one returned t complete the inspection on 25 October 2018. During our inspection visit, we spoke with four people who lived at the home. We spoke with four members of staff, the registered manager and the regional manager.

To help us assess how people's care needs were being met we reviewed all, or part of, three people's care records and other information, for example their risk assessments. We also looked at the medicines records of five people, four staff recruitment files, training records and a range of records relating to the running of the service.

During our inspection we asked the registered manager to send us further information about staff training. We did not receive this prior to writing this report.

We did not request a Provider Information Return prior to this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what they do well and improvements they plan to make. However, on the day of inspection we gave the provider the opportunity to share this information.

Requires Improvement

Is the service safe?

Our findings

At our past three inspections we found concerns about the management of risks associated with people's care and support. This has been an ongoing a breach of the legal regulations. At this inspection, we found continued concerns about the management of people's behaviour. Staff did not always have sufficient training to ensure people were safely supported with behaviours that could place them or others at risk. For example, an incident record showed one person had required a high level physical intervention to reduce the risk of them causing harm to themselves or others. However, two of the four staff involved did not have the required training. We were not provided with training information for four staff who had been involved in high level physical interventions. This failure to ensure staff had sufficient training placed the person at risk of sustaining injuries as a result of unsafe physical intervention.

Records of physical interventions were not always fully completed, which meant there was not always evidence to demonstrate physical interventions had been performed safely. Incident forms did not always indicate exactly how the interventions were managed. For example, a record documented two staff were involved in a high level physical intervention, one holding the person's legs and another holding their arms. This was not a safe way of performing this intervention and could have led to injury. The registered manager told us this was a recording error.

There were systems in place to learn from accidents and incidents; however, actions taken to reduce the risk of repeat events were not always clearly recorded. For instance, records showed there had been a delay in staff attending to someone who had caused harm to themselves as staff were not clear of their role. Although the incident form had been reviewed there was no information about what action had been taken to prevent this happening again. We discussed this with the registered manager who told us they had addressed this with the staff involved but they had not recorded this.

Risks associated with people's health needs were not always managed safely. The local authority safeguarding adults team had recently investigated three safeguarding concerns, primarily into allegations of neglect of people's health needs. The safeguarding investigations found two allegations of neglect were substantiated. This related to a failure to identify and address risks associated with specific medicines, and a failure to seek timely medical advice for people. The investigations concluded this had resulted in harm. The third safeguarding concern remained under investigation at the time of writing this report.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other than the above we found staff had a good knowledge of how to manage risks associated with people's care and support. There were risk assessments in place to across a range of areas and these contained clear details of the support people required to stay safe. Staff explained what they did to keep people safe, such as conducting room searches to identify potentially dangerous items.

People living at the home told us their feelings of safety depended upon the number of incidents at the

home. Although people said they felt safe at the time of our inspection, they spoke of recent incidents which had made them feel unsettled and unsafe.

Referrals had not always been made to the local authority safeguarding adults team. Records showed some referrals had been made to the local authority safeguarding adults team; however, we identified other incidents that placed people at risk of harm, such as incidents where people had caused harm to themselves requiring hospital treatment, which had not been reported as required. This meant there was a risk safeguarding incidents may not be appropriately investigated. We discussed this with the registered manager who told us they did not know some incidents should be reported and said they would ensure referrals were made in the future.

Further work was needed to ensure people were protected from the risk of legionella. Legionella is a bacterium which can develop in stagnant water and lead to a fatal form of pneumonia. A legionella risk assessment advised that infrequently used water outlets should be run on a weekly basis to reduce the risk of bacteria developing in the water supply. However, there were no records to show that this was completed. This increased the risk of legionella developing in the water supply and placed people at risk of contracting Legionnaires Disease. The registered manager advised us they would address this immediately. In contrast, other risks associated with the environment were managed safely. There was a fire risk assessment in place and people who used the service were regularly provided with information about evacuation procedures to be followed in the event of an emergency. High risk items such as cleaning chemical and sharps were locked away and staff were aware of specific risk items that could not be brought into the home.

There were enough staff available to meet people's needs and ensure their safety. People living at the home told us there were enough staff and this view was also shared by staff. One person told us, "There are plenty of staff." Staffing rotas showed shifts were staffed at, or above, the level determined as safe by the provider and people were provided with the one to one support that was funded for them. Staff were also supported by an on-call manager who could be contacted in the event of an emergency.

At our March 2018 inspection we found safe recruitment practices were not followed. This was a breach of the legal regulations. At this inspection we found improvements had been made. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal record checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

Overall medicines were managed safely and records showed people received their medicines as prescribed. People told us they got their medicines when they needed them. One person told us, "They explain medication that I take and it is always same time each day. I don't think it's late." Some improvements were required to ensure staff had clear information about how to administer medicines what were prescribed to be given 'as needed.' Immediate improvements were made in this area during the inspection.

Good hygiene practices were followed and overall the environment was clean and hygienic. Some staff had training in infection control and basic food hygiene. We observed the kitchen area to be clean and well maintained and staff followed food hygiene procedures.

Requires Improvement

Is the service well-led?

Our findings

At our past three inspections we have found concerns in relation to the leadership and governance of Heathcotes (Moorgreen). The overall rating for this service is rated as Requires Improvement. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding.' Good care is the minimum that people receiving services should expect and deserve to receive. The service has been rated as 'Requires Improvement or Inadequate' on five consecutive inspections. This shows that effective systems were not in place to ensure the quality of care was regularly assessed, monitored and improved.

Auditing systems were not fully effective in addressing areas for development. The provider conducted regular audits and overall these were effective in identifying issues. However, actions planned to address areas of concern had not always been completed. An action plan developed in July 2018, stated staff would be required to attend supervision sessions run by the therapy team to improve consistency of support, increase staff resilience and develop their response to people's behaviours. However, the therapy team told us that staff attendance at these sessions was poor. In addition, there were no records kept of staff who had attended sessions which meant the registered manager was unable to monitor this and address any concerns. This failure to implement effective systems meant opportunities to improve the service may not be identified.

Records of people's care and support were not always accurate and up to date. Support plans were reviewed at specific intervals; however, support plans had not always been updated between formal reviews to reflect changes. For example, one person's care plan stated they self-administered some of their medicines. However, this was not the case at the time of our inspection as it had been deemed too risky. Despite this, their support plan had not been amended to reflect this. Other high-risk items had also been removed from the person, the registered manager told us the person had agreed to this. However, there was no evidence the person had consented to this and there was no formal plan in place detailing how to support the person to regain control in this area. This failure to keep up to date records meant the registered manager could not assure us people's rights had been respected.

Other records were also incomplete. Records of incidents had not always been fully completed to show what action had been taken in response to adverse events, and investigations into more serious concerns were not documented. An incident record showed a person had being subjected to serious threats. There was no evidence that this had been reported to the police or the local authority safeguarding team. The registered manager told us they had spoken to the person who did not want it reported and told us they had informed safeguarding. However, there was no record of this and the local safeguarding team were not aware of this concern. This meant there was a risk action many not be taken to protect people from harm.

There was limited evidence to demonstrate what action had been taken by the registered manager in response to adverse incidents. Records showed a person had missed their medicines as they had not been delivered. The record stated, 'medicines to be ordered on time' in the lesson learned section. We discussed with this the registered who told us the person had not actually missed their medicines and the error was due to the pharmacy not supplying the medicine in time. This was contrary to information documented on

the incident form and there was no written investigation or evidence of action from the registered manager. This meant it was unclear what action had been taken to prevent this from happening again.

Further work was required to ensure staff had the knowledge and skills to deliver the provider's vision for Heathcotes (Moorgreen). The provider's website stated Heathcotes (Moorgreen) was a 'Specialist treatment centre that supports eight individuals with emotionally unstable personality disorders' and that staff were 'specially trained in personality disorder.' However, other than the input from the therapy team, we found staff did not all have sufficient knowledge or training to enable the provider to deliver the specialist aspects of the service. For example, records showed that only 14 of the 30 staff employed at the service had training in personality disorder. Some of the staff we spoke with lacked knowledge in the area. We asked a member of staff about the staff supervisions provided by the therapy team, and they told us they did not go as "I don't really know if it would help me." This had been identified at previous inspections, however the provider had not taken effective action to address this. This meant there was a risk people may not receive effective support in relation to their mental health needs.

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

We checked our records, which showed the provider, had not notified us of all events in the home. A notification is information about important events, which the provider is required to send us by law, such as serious injuries and allegations of abuse. We had not been notified of some serious injuries sustained by people living at the home. A failure to notify CQC of such incidents has an impact on the ability of the CQC to monitor the safety and quality of the service. Although the registered manager told us this was a misunderstanding, we had identified this concern at previous inspections and the provider had failed to implement effective systems to ensure notifications were made.

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

There was a registered manager in post at the time of our inspection, he had been in post since June 2018 and had experience of managing another similar service. People living at Heathcotes (Moorgreen) were positive about the registered manager. One person told us, "He is the most reliable manager that has ever been here, he listens to me and respects my choices."

Staff were also positive about the impact of the registered manager. A member of staff told us, "[Registered manager] listens to what you say. He'd act on suggestions." Staff told us they felt supported and said they were encouraged to have discussions following serious incidents, to reflect on learning and their own wellbeing. One member of staff told us, "After major incidents we all have a chat, throw it out round a table. What we could have done, or not done." The registered manager told us they kept up to date with new developments in various ways including, meeting with other registered managers and via policy updates from the provider.

People were involved in the running of the home. Meetings were held with each person on an individual basis. We saw records of these meetings which showed that they were used to discuss areas such as activities, food and concerns. Results of recent satisfaction surveys for people and their families were positive. Areas for improvement had been acted upon. For example, a suggestion had been made about improving the smoking area, and this had been completed. The registered manager had taken action to try to address concerns raised by people living at the home. Some people had raised concerns about night staff sleeping on shift. Records showed the registered manager conducted spot checks at night to monitor this.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their most recent rating on their website and in the home.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not adequately protected from risks associated with their care and support. Improvements were needed to ensure learning from accidents and incidents was clearly documented. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not always effective in ensuring action was taken to address issues. Records of people's care and support were not always accurate and up to date and other records were incomplete. Further work was required to ensure staff had the knowledge and skills to deliver the specialist aspects of the service. Regulation 17 (1) (2)