Heathcotes Care Limited

Heathcotes Chesterfield (Loundsley House)

Inspection report

Loundsley House
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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

About the service
About the service
Heathcotes Chesterfield (Loundsley House) is a residential care home for people with learning disabilities, and/or autism and complex mental health needs. The care is provided in a purpose-built home for eight people. There were seven people living at the home at the time of our inspection.

People's experience of using this service and what we found

The provider had made many improvements however some were not yet fully embedded to provide us with assurances to support sustainability. These were in respect of audits of the home and the continued risk management.

Relatives and professionals had reflected on the improvements, however they felt further improvements could be developed in relation to communication.

Staff had been recruited to the service, however not all the required employment checks had been completed to provide assurances about staff being suitable to work with people.

The culture of the home had been improved and reflected the principles in relation to Right support, right care, right culture. 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 able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. People were supported to make decisions about the care they received and how they spent their time. Prior to COVID 19 community links had been established and these will be returned to once the restrictions allow.

People received personalised care in an improved homely environment, which had been refurbished in consultation with the people using the service. People were encouraged to make choices about their diet, activities and how they spent their day.

There were sufficient staff to support people and staff now felt supported and received regular supervision for their role. Training had been improved to provide staff with the required skills.

Staff understood how to raise a safeguarding alert or concern. Any received had been investigated and any outcomes had been used to make improvements to people's safety. Risk assessments had been completed

to ensure measures were put in place to mitigate the risks. Referrals were made to obtain health and social care advice and we saw this was recorded and followed. Medicines were managed safely to ensure people received their prescribed medicine.

Relationships had been maintained through the use of technology and outside visits. Social stories had also been used to ensure continued family connections.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The provider had worked in partnership with health and social care professionals, we saw improvements had been made and lessons had been learnt.

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 Inadequate (published 8 September 2020)

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

This service has been in Special Measures since 19 February 2020. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We undertook this focused inspection to check the provider had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Inadequate to 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 <Name of location> 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 Chesterfield (Loundsley House)

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 inspection was completed by two inspectors.

Service and service type
Heathcotes Chesterfield (Loundsley House) 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. 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 the 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 took this into account when we inspected the service and made the judgements in this report. 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 all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with three members of staff including the registered manager and quality lead. We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We received written feedback from three professionals who regularly visit the service. We made telephone calls to three relatives and four staff.

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 Inadequate. At this inspection this key question has now improved 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
At our last two inspections the provider had failed to provide enough, suitably qualified and experienced staff. This was a breach of Regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations, however improvements were still needed.

- At our last inspection we found effective recruitment practices were not in place to ensure that staff were of good character and sufficiently experienced. At this inspection we found improvements had been made although we saw employment histories had not always been explored and two references had not been obtained to comply with the providers recruitment policy.
- Staff confirmed and records reflected that satisfactory criminal records checks had been completed before new staff started to work at the service.
- New staff completed an induction and worked alongside experienced staff before working as part of the staff team. One staff member told us, "I was supported with training and experienced staff to help me get to know people and know how support them individually."
- We reviewed staff rotas and spoke with staff, which confirmed there were enough suitably experienced, skilled and qualified permanent staff deployed to meet people's individual support needs. One person told us, "Staff are ok, they know me well."

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
At our last two inspections the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations, although further improvements are still needed.

- We saw that improvements had been made to risk management processes; however, we would want to ensure these approaches had been embedded and continue to be used to reflect and reduce risks.
- On our last inspection we found that people were at risk of further harm as they were not supported to manage behaviours which could harm themselves or others. On this inspection, we found risks to people's health and well being had had been reviewed to ensure staff knew how to safely support people.
- The assessments included how to identify any known triggers for complex behaviour, diversion methods

and agreed support needed. There was evidence that family members had been involved with the assessments although there was no agreement that the plan had been agreed by health or social care professionals.
● Following any complex behaviour, incidents were analysed, and staff were given an opportunity to discuss events and look at where lessons could be learned.
● Care plans and incidents were reviewed to reduce the risk of incidents being repeated and to help to evidence how effective the plans were.

Preventing and controlling infection
At our last two inspections the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations, although further improvements are still needed.
● On our last inspection we found that staff were not following infection prevention and control procedures to protect themselves or people using the service against the risk associated with COVID-19. At this inspection, we found Infection control practices had been reviewed and when people entered the building, masks were worn, their temperature was taken, and health questionnaires were completed.
● Hand gel and protective personal equipment (PPE) was available in the home and we saw this was used by staff.
● Further improvements were still needed, we observed that when face masks were touched, these were not always disposed of and new masks used. When staff had their breaks, this was in communal parts of the home and as staff were eating and drinking, masks had been removed. Following our inspection these concerns had been addressed.
●The staff now only worked in this service to prevent the risk of cross contamination of any infection.
● 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 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.

Using medicines safely
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.
● On our last inspection we found medicines management systems had not ensured people were receiving medicines to keep safe. On this inspection, we found people's medicines were now stored, managed and disposed of safely and they were provided with safe and appropriate levels of support.
● Staff were trained and had their competencies checked by senior colleagues. This meant they supported people to take their medicines at the right time and in accordance with the prescriber's instructions.

● The provider had developed policies and procedures to help ensure safe administration of medication and daily audits were completed to ensure people had received their medicines as required.
● When people were prescribed 'as required' (PRN) medicines there were clear guidance to follow. This ensured that all alternative options had been explored before using medicine to manage the situation. We saw there had been a reduction in the use of PRN medicines.

Systems and processes to safeguard people from the risk of abuse
At our last two inspections the provider had not ensured that systems were safeguarding people and reducing the risk of harm. 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.
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations, however improvements were still needed.
● At our last inspection we raised concerns about insufficient oversight of physical restraint to ensure it was not overly restricting people in line with their human rights. At this inspection we found restrictions for people's liberty to move freely had improved.
● Staff were knowledgeable regarding how to support people to manage complex behaviour using distraction techniques and speaking with them. We saw the number of incidents occurring had reduced and chemical and physical restraint had only been used on a small number of occasions.
● Where safeguards had been raised these had been investigated and any measures to reduce ongoing risks had been implemented. This meant systems were now in place to ensure people were safe and well protected from the potential risks of abuse and avoidable harm.
● A social care professional said, "There have been a couple of safeguarding concerns that have been raised and these have been dealt with effectively. Any information requests have been dealt with promptly and where necessary, the appropriate course of action has been taken by the provider."

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 Inadequate. At this inspection this key question has now improved 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.

At our last two inspections the provider had not always manage risk and responded or act on feedback. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations, however improvements were still needed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;
● The provider had been rated inadequate for the last two inspections. Although at this inspection we found improvements had been made we would want to ensure these were sustainable and we will continue to monitor the service along with the local authority.
● Relatives, health and social care professionals we spoke with all felt that improvements had been made. However, they had all identified that communication could be improved in sharing ongoing developments within the home.
● The provider had reviewed the use of audits to ensure how they drive improvements or to ensure the quality of care was being maintained. However, we found some areas improvements within the environment had not been identified and we would want to be assured of a consistent approach in identifying and responding to concerns.
● Although we found staff felt confident to raise any concerns through the whistle blowing and safeguard policy, we identified the policies were not open and transparent or in line with current guidance in these areas. We have asked the provider to review this area and share with us any changes to the policies.
● Staff we spoke with felt they were now supported with their training and development. One staff member said, "Things are now into place, like personal development plans and these are linked to the person-centred care." Another said, "We are now consulted to collaborated on paperwork more effectively, for example the handover documentation."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People had been supported to understand the current COVID 19 restrictions. One person told us, "Staff are doing what they can to keep us informed, along with keeping occupied and busy."
● People had been consulted about the environment of the home, we saw that communal areas had been

decorated and new furniture had been purchased. One person had their bedroom decorated and photographs had been shared with family due to them being unable to visit at this time. A social care professional said, "There is a vast improvement in the environment which is now more homely."

●People were supported to keep in contact with family members. One relative said, "We talk daily on the telephone, they seem happy and settled." We saw that social stories had also been used to support contact when telephone or skype calls were unsuitable.

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

● Improvements had been made to the culture of the home. We saw people were supported to be more inclusive in the care they received. One staff member said, "You can tell the improvements, people's incidents have reduced. The staff know how to support people to reduce anxiety."

● The provider had increased their recruitment to ensure people received consistent staff. One person said, "Staff are really supportive, and we now see regular faces." A social care professional confirmed that the person they supported received their required one to one time and this was provided by regular staff who the person felt comfortable with. The increased recruitment had also ensured staff now worked regular hours and in accordance with working time directives.

● Staff had received training both online and some face to face to refresh or increase their knowledge. Staff we spoke with felt this area had improved and they now had the skills they required for their role.

● Incident were now reviewed, and measures put in place to reduce the risks. Health and social care professionals had been consulted to provider additional support when the needs were reflective of people's long-term health condition or in relation to behaviours which challenge.

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 had ensured that they send us notifications of events or incidents, this meant we could monitor how the service responds to these.

● Relatives shared with us that they felt the provider had been responsive during the COVID 19 outbreak.

Working in partnership with others

● The provider and registered manager had worked with a range of partners to drive improvements. For example, the local authority in relation to managing incidents.

● Relatives we spoke with had reflected that communication with regard to incidents or concerns had improved.

● The registered manager had made referrals to professionals to support people's individual needs. For example, a chiropodist and a dietitian. The advice and guidance from these were shared with staff and reflected in risk assessments and the care plans.

● The provider and registered manager had worked with health and social care professionals to ensure the home is following best practice or updated guidance.