Heathcotes Care Limited

Heathcotes (Blythe Bridge)

Inspection report

Southlands
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 26 and 29 January 2018. At our previous inspection we had no concerns about the quality of care and had rated this service as good. At this inspection we had serious concerns about the safety of people who used the service and found six 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 service is rated as inadequate and will be placed into special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Heathcotes (Blythe Bridge) provides accommodation and personal care for eight people who have learning disabilities and associated complex needs. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.' Registering the Right Support CQC policy. At the time of the inspection eight people were using the service.

There was a registered manager in post. 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.

There were insufficient numbers of staff to meet people's assessed needs and people were not being safeguarded from the risk of abuse due to a lack of staff to keep them safe. People's risk assessments were not always followed to minimise the risk of harm. This had resulted in people being harmed in the home and continuing to be exposed to the risk of harm. People's medicines were not always being administered safely.

The systems the provider had in place to monitor the quality of the service had not been effective. Prompt action had not been taken to improve the service for people. The provider had not taken action following incidents to protect people. The provider had not considered people's experience of living in the home.

People's needs were not always identified and assessed effectively to ensure they would be met safely.

The provider was not effectively following the principles of the Mental Capacity Act 2005 and ensuring that when people lacked the mental capacity to agree to their care they were supported to do so in their best interests.

People who used the service were not always treated with dignity and respect. Staff did not always refer to people respectfully or understand their specific needs.

When people became unwell the appropriate health care support was gained in a timely manner and people were supported to eat and drink sufficient amounts to remain healthy.

People were offered choices and these choices were respected and people's right to privacy was supported.

The provider had a complaints procedure and responded to concerns raised appropriately.

People who used the service would be supported with decisions about how they wished to be cared for at the end of their life.

New staff were employed using safe recruitment procedures to ensure they were of good character to work with people who used the service.

Staff at the service felt that the registered manager was approachable and supportive and people who used the service were comfortable in the presence of the registered manager.

The registered manager knew their responsibilities in relation to their registration with us.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were insufficient numbers of staff to meet people's assessed needs and keep them safe.

Risks of harm to people were not being reduced due to a lack of available staff.

People were not being safeguarded from the risk of abuse and lessons were not learned following incidents that had resulted in harm.

People's medicines were not always being administered safely.

New staff were employed using safe recruitment procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were not always identified and assessed effectively to ensure they would be met safely.

The provider was not effectively following the principles of the MCA and ensuring that when people lacked the mental capacity to agree to their care they were supported to do so in their best interests.

When people became unwell the appropriate health care support was gained in a timely manner.

People were supported to eat and drink sufficient amounts to remain healthy.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People who used the service were not always treated with dignity

and respect.

People were offered choices and these choices were respected.

People's right to privacy was supported.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's individual assessed needs were not always able to be met.

The provider had a complaints procedure and responded to concerns raised.

People who used the service would be supported with decisions about how they wished to be cared for at the end of their life.

Is the service well-led?

Inadequate

The service was not well led.

The systems the provider had in place to monitor and improve the quality of the service had not been effective.

Prompt action had not been taken to improve the quality of the service when an area of concern had been identified.

Staff at the service felt that the registered manager was approachable and supportive.

People who used the service were comfortable in the presence of the registered manager.

The registered manager knew their responsibility in relation to their registration with us.

Heathcotes (Blythe Bridge)

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by concerns that had been raised about the staffing levels at the service and an increase of notifications of safeguarding incidents which had been reported to the local authority for further investigation. The information shared with CQC about the incidents indicated potential concerns about the management of risk, staffing levels and the overall management of the service.

This inspection took place on 26 and 29 January 2018.The 26 January was unannounced and the 29 January 2018 was announced. It was undertaken by one inspector.

We spoke with two people who used the service and observed others care and support. We spoke with one relative and had written contact with another. We spoke with three care staff members, the registered manager and two area managers. We spoke with the local authority.

We looked at the care records for three people who used the service. We looked at incident reports, rotas and handover sheets. We looked at the systems the provider had in place to monitor and improve the quality of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection in we had no concerns about the safety of the service. Prior to this inspection we received information of concern about the safety and welfare of people who used the service due to a lack of available staff. At this inspection we found there were insufficient numbers of staff to meet the needs of people and they were not always being safeguarded from the risk of abuse. We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service had been assessed as requiring one to one staff support at specific times throughout the day. This one to one care had been commissioned because people living in the home had complex needs and required this specific care to maintain their safety. Some people required this support all day whilst others required extra support for a proportion of the day. When we arrived on the first day of the inspection we found there were three members of staff on duty. One person required a male member of staff to support them all day and we found that this person was unsupervised whilst their allocated male staff member administered medication to other people who used the service. There were two other people who required one to one support all day and only two other staff members available for these people and the other five people who used the service. Although more staff became available later in the day there were times during the day there were insufficient staff to meet people's needs and keep them safe.

We looked at the rotas and the handover sheets and saw there had been several times and days since December 2018 where there had not been enough available staff to ensure people were receiving their allocated staff support. A relative told us: "There has not been enough staff since the manager changed the rota last year as some staff left then". Staff we spoke with told us that there had been staff shortages and that they had worked extra shifts and stayed on to try and cover the deficiencies. The area manager told us that several staff members had left and not worked their notice and this had left them short of staff. Although they had utilised some staff from one of the provider's other services and they had worked some shifts themselves they were not always on duty at the times they were needed and there were still days that the service was understaffed and unsafe.

We checked to see how well people were protected by the prevention and control of infection. We saw that there was disposable gloves available to staff to use when supporting people with personal care and there was hand wash and paper towels to use in the bathroom areas. Staff we spoke with knew about infection control procedures, however we noted that the house was unclean in places. We observed the bath was dirty with soap scum from a previous person's bath and people's bedrooms would have benefitted from being hoovered and bathroom floors cleaned. We saw that this was noted in the provider's recent quality audit. Care staff were allocated the role of cleaning and they were signing to say they were completing the cleaning tasks however there were insufficient care staff to be able to complete this task effectively as they were providing care and support to people.

People's medicines were stored safely in a locked cabinet in a locked room and they were administered by staff who were trained to do so. Staff had received training in the administration of medicines, however, staff who were administering medicines were also expected to deliver one to one care and this meant that this

was not always being completed in a safe way. For example, on the day of the inspection the staff member who was responsible for administering medicines was the allocated one to one staff member for one person. We saw this person was alone and singing loudly in the corridor and this had the potential to unsettle other people who used the service. We observed the senior staff member with another person's medicines and we observed they were distracted from the task of administering the medicine to ask the person they were supporting to be calm. This meant that the staff member was being distracted from administering the medication safely.

These issues constitute a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were insufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet people's assessed needs and keep them safe.

People's risks were assessed and planned for to protect their safety and wellbeing. People had individual risk assessments that were specific to them and were detailed enough to help staff understand how to manage risks. However, due to a lack of available staff people's risk assessments were not always being followed. We saw an incident record that showed that on one occasion one person who was risk assessed as requiring one to one at all times had been left unsupervised and they had set off the fire alarm. When staff redirected the person and explained that this was for emergencies only this had resulted in the person harming themselves. Staff had recorded on the incident record 'due to staffing levels no one was with [Person's name] when they pressed the alarm'. This showed that there were insufficient staff to meet this person's assessed needs and this had resulted in them harming themselves.

A member of staff told us that at times they were unable to follow people's restraint risk assessments safely due to a lack of staff. They told us there were times when there was no one available to monitor the person's breathing during restraint. This is a crucial role in maintaining the person's health and welfare during the restraint process. This put these people at extreme risk of harm.

These issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people did not feel safe at the service. A relative told us: "My relative is frightened to go back to the service now as they have been assaulted". This was due to a new person who had been admitted into the service who had complex needs and at times became anxious and aggressive towards other people who used the service and the staff. This person was assessed as requiring one to one male support. We saw this person had a risk assessment which stated that if there were no male staff available to support this person then they should be asked to go to their room. This was not an adequate way of supporting this person and was an infringement on their rights. The area manager told us that they had recognised that the service could not meet this person's needs and they were in the process of seeking another placement for the person. Although the incidents of abuse had been raised with the local safeguarding authorities' decisive action had not been taken to reduce the risk of incidents to the other people who used the service such as increase in the staffing levels. We saw one safeguarding investigation had highlighted that there was a lack of staff to meet people's needs safely and no action was taken to increase the staffing levels. This meant that people were not being safeguarded from the risk of abuse and lessons were not being learned from incidents so improvements could be made. This had resulted in people being subjected to the on-going risk of harm.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the way in which the provider employed new staff and found that they were using safe recruitment procedures to ensure prospective staff were suitable to work with people who used the service. Pre-employment checks included the completion of disclosure and barring service (DBS) checks. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we had no concerns in the effectiveness of the service. At this inspection we found that the service required improvement as the principles of the Mental Capacity Act 2005 (MCA) were not always being followed and people's needs were not always assessed effectively to ensure they could be met safely.

We checked to see if people's needs and choices and their assessed care, treatment and support were delivered in line with current legislation to achieve effective outcomes. We found that the assessment of people's care and support needs was ineffective as even though an assessment of one person's needs was carried out, the provider was unable to safely deliver the care and support they required. The provider had accepted a new admission into the home however had not fully considered how they would meet this person's needs safely alongside maintaining the safety of the other people already living in the home. Staff at the service had not alerted the person's social worker to the problems they were having in meeting their needs. This placed the person and others at risk of receiving inadequate care and support as the assessment of this person's needs was ineffective and the provider had not worked with the relevant social care and health agencies to ensure this person's needs was met. The provider acknowledged this and had since taken action to support the person to find an alternative placement.

The Mental Capacity Act 2005 (MCA) sets out requirements that ensure where appropriate; decisions are made in people's best interests when they are unable to do this for themselves and the Deprivation of Liberty Safeguards (DoLS) are for people who are unable to make a decision about where or how they are supported and they need someone else to make this decision for them. We saw that one person had been assessed as not having the mental capacity to agree to being at the service and had been referred for a DoLS. However, we saw on their admission they had other 'boundaries' that had been put in place such as not being able to have access to the internet and having to ask to go for a cigarette. These boundaries had not been agreed through the DoLS procedure or a best interests meeting and as such may be a deprivation of their liberty. On day two of our inspection this person was informed they would not be able to go out into the community until they had tidied their room. This then caused them to become anxious and threatening towards staff and this led to the person not being able to go into the community for theirs and staff' safety. This person's mental capacity to understand the boundaries and consequences of their actions in relation to their behaviour had not been assessed effectively and this person was at risk of having their liberty restricted.

These issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not always being supported to consent to their care and support.

Staff we spoke with told us that although they received supervision and training to fulfil their roles there had not been enough staff at times during the last few weeks and it had been a stressful period. A relative also told us: "Prior to December we had a great deal of confidence in the staff. Since that time there has been a huge turnover of staff, with many staff being brought in from other homes in recent weeks. Today we went to visit [Person's name] and there was only the Manager and one other member of staff that we knew. Based

on that visit, and others recently we cannot have confidence in the staff as we do not know them". We saw that during this time the area manager had supported staff and worked alongside them to cover some of the staff vacancies. One staff member told us: "It's been a stressful time but we have bonded as a team and are stronger now".

People had access to a choice of meals and were supported by staff to eat and drink sufficient amounts. One person had been identified to have lost a significant amount of weight. These concerns had been shared with the person's GP. We observed a food and fluid chart had been put in place. This enabled the staff to monitor the amount the person ate and drank. Staff informed us that no one required a special diet. However, one person required their food to be cut up to reduce the risk of them choking.

When people became unwell or their health needs changed they were supported by staff to seek advice. People had access to a range of health care agencies such as their GP, consultant psychiatrist and other health professionals. This meant that people's health care needs were met.

The design and decoration of the building met the needs of people who used the service. Each person had their own room which had an ensuite and there were separate bath and shower facilities. Bedrooms had been decorated to each person's individual preference, for example one person had the colours of their favourite football club and another person had sensory lights. There was a quiet room for people to spend quiet time away from others, a main lounge, dining room, kitchen and a garden for summer activities.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we had no concerns in how people were treated. At this inspection we found that not all interactions between staff and people who used the service were respectful.

Whilst sitting in the office, we heard one person asking for some breakfast and heard a member of staff reply by saying: "You've just had your breakfast, don't be greedy, you're not having anything". This did not demonstrate a kind and caring attitude towards this person. We did not see who this conversation was directed at and who the staff member was. The registered manager assured us that they would try to identify who it was and act accordingly.

We spoke to one member of staff who described some of the people as being 'naughty and kicking off' when they became anxious and at times aggressive due to their learning disabilities and associated behavioural needs. We also saw records where a staff member had recorded on several incident records that a person was 'attention seeking' when they had behaved in certain way and it was also recorded on another incident form that a staff member had been 'disgusted with a person's behaviour'. These statements did not demonstrate that staff valued people and had understanding and empathy with people and their needs.

This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not always treated with kindness, respect and compassion, were not always given the emotional support when needed.

We saw and heard other interactions between staff and people who used the service that were kind and caring. For example, one person was laughing and joking with staff and was comfortable to chat and banter. A member of staff told us: "I love my job, no two days are the same. It's the little things that mean such a lot. If I can get [Person's name] to join us in the lounge even for five minutes I feel a sense of achievement as they usually isolate themselves".

People were supported to maintain relationships with people important to them such as their relatives. Staff took people to their relative's home for visits and relatives were free to visit. One person regularly used the telephone to ring their relative as they did on the day of the inspection. They happily chatted and told their relative about what they had been doing and how they were.

Most people had their own regular routines which they maintained and staff knew these routines and respected them. People were involved in their care planning and in the running of the home as much as they were able to be. One person had an 'advocate' and we saw there were regular house meetings where people could make suggestions and requests.

People had their own bedroom and a key if they chose to have one. One person showed us their room which they kept locked. People could choose to spend time in their room if they wished and this was respected by staff.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we had no concerns in the responsiveness of the service. At this inspection we found that improvements were required.

Care plans and risk assessments we looked at were clear and comprehensive and included people's individual preferences, however we found that people were not always receiving the care that met their personal assessed needs due to a lack of available staff. The area manager told us that they were unable to meet the needs of one person who had been recently admitted into the service. We looked at this person's pre-assessment information and saw that they were at high risk of harming themselves and others. The area manager told us that they felt they could meet the person's needs at the time of their admission yet they had not responded quickly to increase the staffing and find a more suitable placement to ensure that this person's needs and the safety of other people were considered when they realised that they could not. People had been harmed and put at risk due to the ineffective assessment process and the lack of recognition that people who used the service would be vulnerable and at risk.

We were informed by a relative and a member of staff that one person had taken to staying in their room more often as they were afraid. Even though this had been noted the provider had not responded and ensured that this person was not being put at risk of social isolation.

People were supported to be involved in hobbies and activities of their liking. We were informed by a member of staff that some activities had not taken place due to a lack of staff. Records we looked at did not evidence this. One person only enjoyed going to the local shop and we saw they did this at least once a day. Other people enjoyed a range of activities including, shopping and eating out. We saw that through the period of being understaffed that staff had facilitated for people to continue with their community activities, although this at times had left the home short of staff.

One person who used the service told us they would talk to the area manager if they had any concerns. We saw that the provider had a complaints procedure and that it was available in a pictorial form to support people's understanding. The registered manager showed us that they had received one recent complaint and that they had responded to it. This meant people could be confident their concerns would be listened to and acted on.

Plans for people's care at the end of their life had been considered. Two people had a funeral plan which their relatives had put in place for them. The registered manager told us that 'end of life' decisions would be discussed with people and their relatives at a time it became relevant.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we found that this area required improvement as the manager had not registered with us as they are required to do. Since the last inspection the manager had registered however we found further concerns about the management of the service.

Prior to this inspection we had received concerns about staffing levels in the home. We were informed that staff had resigned without giving notice due to the stress this had caused them. We found that the provider's governance was ineffective to ensure there were sufficient staffing levels to meet people assessed needs. This had an implication on the safety of both people who used the service and staff. A relative told us: "It is difficult to understand why so many staff have left in recent months. The lengths of shifts were changed, apparently with the cooperation of the staff, but many of the departures have occurred since that time. Support from the organisation outside the home seems to be poor". The provider was unable to tell us what action they would take to resolve the staffing problems. and this meant people remained at risk of not receiving the appropriate care and support. The provider did not recognise that the insufficient staffing levels in the home were impacting upon people's experience of receiving care and support and placing them at risk of harm. Despite a significant increase in incidents in the home including incidents of people being assaulted, appropriate action had not been taken by the provider to protect people or to review the staffing levels in the home.

We looked at the provider's business continuity plan and saw that the area manager had followed the plan yet had stopped short of seeking permission from the provider to use agency staff. The area manager told us that they could not source an agency that would supply staff who were trained in the same physical intervention training as the provider's staff. Yet on the second day we were informed by another area manager that the provider would not allow the use of agency staff. The provider's business continuity plan to ensure safe staffing levels was not followed so had not been effective.

The provider's governance systems were ineffective in ensuring people's needs were appropriately assessed before they moved into the home. This had led to one person not receiving the necessary support to protect them and others from the risk of harm.

The governance systems did not review or monitor that the principles of the MCA was incorporated into care practices to ensure people's liberty was not being unlawfully deprived. We also found a best interest decision had not been made to ensure people received the appropriate support to go out and to have a cigarette when they wished.

The governance failed to identify inappropriate comments recorded in care records by staff. We saw incident reports where a member of staff had used inappropriate language in describing people who used the service. The registered manager told us that they had identified issues with this staff member previously but they were unable to show us that they had taken action to manage this member of staff's performance through the formal support and supervision process. This meant that this staff member would not have the opportunity to improve their performance and the care the support they gave to people who used the

service.

The providers governance systems failed to consider people's experience of living in the home. We observed and feedback from people told us that they did not feel safe living in the home. The provider had not gathered or used feedback from people or deployed systems to recognise this. Therefore people were not comfortable living in the home and were at risk of becoming isolated because they were spending significant amounts of time in their bedroom where they felt safe.

These issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some staff had left as they did not feel supported, staff we spoke with told us that the registered manager was supportive and approachable. There were regular staff meetings and meetings for people who used the service and we saw that people were comfortable in the company of the registered manager and able to approach them with any concerns they had. However, despite staff feeling able to raise concerns these had not been acted upon appropriately by the provider or senior staff.

The registered manager knew their responsibilities in relation to their registration with us (CQC) and had notified us of significant events which they are required to do by law.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always being treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the MCA were not being consistently followed to ensure people consented to their care and support.

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 always receiving safe care and treatment.

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 being safeguarded from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems the provider had in place to

monitor and improve the service were not effective.