Heathcotes Care Limited

Heathcotes (Taylor View and Gilbert Lodge)

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Heathcotes (Taylor View and Gilbert 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 (Taylor View and Gilbert Lodge) provides support for up to 10 people with a learning disability and those with autistic spectrum disorder. At the time of our first visit on 4 June 2019 there were nine people using the service. On our second visit on 13 June 2019 there were eight people.

The home is located in two houses which are located either side of a tarmac drive. Heathcotes Taylor View and Gilbert Lodge is registered as one location, but the two homes operate separately.

We carried out an unannounced comprehensive inspection of this service in May 2018 and the service was rated as Good.

Since our May 2018 inspection we received concerns in relation to the safety of care provided at Heathcotes (Taylor View and Gilbert Lodge). As a result, we undertook this focused inspection to investigate 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 (Taylor View and Gilbert Lodge) on our website at www.cqc.org.uk.

During our inspection we found the service was not consistently safe. Comprehensive assessments had not taken place prior to people being offered a place at Heathcotes (Taylor View and Gilbert Lodge). This meant that staff and management could not assess if all support needs could be met or if there was appropriate staff training in place to ensure that staff could best support people.

We saw that people were being restrained frequently, this should only be as a last resort and if other interventions had failed. Staff were unable to recognise different techniques for de-escalation or fully understand triggers to challenging behaviour.
The service was not using the values and principals of Registering the Right Support and good practise guidance. This would ensure that people using the service can live as full a life as possible and achieve the best possible outcomes. The principals reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice and independence. People using the service did not receive co-ordinated person-centred support which was appropriate and exclusive for them.

Heathcotes (Taylor View and Gilbert Lodge) 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.

Enforcement: You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service well-led? The service was not Well-Led.	**Inadequate**

Heathcotes (Taylor View and Gilbert 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.

Inspection team
Two inspectors carried out this inspection

We received concerns in relation to the management of care of people using the service. As a result, we undertook a focused inspection to review the Key Question 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.

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the service under the Care Act 2014. The inspection was a focused inspection and we looked at evidence to support if the service was safe and well-led.

Service and service type: Heathcotes (Taylor View and Gilbert Lodge) is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection in relation to safe and well led which we focussed on.

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.
Inspection team
The inspection was carried out by two inspectors

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We received information from commissioners relating to concerns at the service

During our inspection we spoke with two people who lived at the home. We also spoke with four staff, the registered manager, service manager and area manager. We reviewed records related to the care of seven people. We looked at records of accidents and incidents, audits and quality assurance reports, complaints, staff files and the staff duty rota. We looked at documentation related to the safety and suitability of the service including medicines management and spent time observing interactions between staff and people within the communal areas of the home.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.
This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
● Staff understood the signs of potential abuse but had only started to receive specific training in how to safeguard children and young adults in June 2019. The service had been supporting young people since December 2018. This meant that staff had not been adequately trained to protect the young people they had been supporting. This meant that people could have been at an increased risk of not being adequately protected during this period.
●A staff member told us they had seen a person being prevented from going out on an activity even though the person was calm and ready to go. This led to the person becoming increasingly agitated and upset. The staff member told us that this had been decided in their best interest following an earlier incident. This was likely to create an escalation of further incidents.
● Staff told us they did not always report issues that they were concerned about to their managers, because they did not believe that their concerns would be listened to or acted on.

Assessing risk, safety monitoring and management
●Risks were not appropriately assessed throughout the service. Pre-admission assessments had not taken place. This meant that people who were being considered to live at the service were not adequately assessed to ensure that their needs could be met. As a result, some staff had not received training to meet people's specific needs. The service manager told us they were only allocated a few places on training courses by the provider.
●Risk assessments and updated support plans for a young person who posed a risk of injury to themselves were only introduced after our first visit . The same person was also a risk to other people living at the service, but this had not been identified by the provider, at the time of our first visit.
● The service manager told us they had not been able to obtain important background information about a person. That information was essential as it impacted on the way the person should be supported and also identified potential risks faced by the people they lived with.

This is a breach of Regulation 9 (3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
●There were enough staff to support people at the time of our visit. The staff were not adequately trained to meet the needs of all the people they supported.
●Some staff were from other nearby services owned by the same provider. Staff, were therefore providing support for people they did not know and found it difficult to provide appropriate support tailored to the

needs of the individual.

●One staff member told us "Staff used to really like working here, but not now, it's like treading on eggshells.'' They also told us staff were not appropriately trained to do their jobs. There was no training offered that covered children and young people's autism and how best to support reducing behaviours that may be challenging.

Using medicines safely

●Medicines audits were not effective; medicines errors had been made which were not picked up by the audits.

●Medication Administration Records (MAR) were not completed correctly. There was missing information that included the GP details, allergies, start date, end date and the actual date of administration. There were handwritten entries which were incorrect and several missed doses were evident on the record form. One of the entries was by a member of staff who had altered the written dosage instructions on the record. This can only be done by a qualified medical practitioner or with the written authorisation of a GP.

●One person had a protocol in place for medicine which was to be taken as required (PRN). The protocol was put in place on 04/08/2017 and should have been reviewed on 04/08/2018. The review had not taken place.

Preventing and controlling infection

●The home wasn't always clean. When we arrived in Taylor View there was food splashed up the inside of a lounge door. Staff told us that this had been a person who had thrown their dinner at the door. When we returned on 13 June 2019 the door hadn't been cleaned and the food was still there.

●Staff were aware of infection control procedures, but we could see no evidence that training in infection prevention and control had taken place or that infection control was being managed.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Learning lessons when things go wrong

●There had been a failure to learn from incidents. There were review sheets for incident logs but in most cases the reviews hadn't taken place and where they had, they were ineffective. Potential lessons learned were not incorporated into staff guidance, training and support plans to prevent further incidents.

●An audit of the service was previously carried out by the provider. This highlighted concerns regarding the safety of the service. At the time of our visit there was no evidence of action taken from the audit and improvements had not been made.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.
This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff told us that they would talk to their immediate manager but would not speak with more senior management. One staff member told us "We wouldn't be listened to and [senior manager] never talks to anyone, not even the people who live here.''
●The provider made decisions about admitting people to live at the service without adequately discussing them with the registered manager or staff at the service. This means that people offered a place to live there had not been adequately assessed to determine their suitability. Without the input of the registered manager and staff who would be required to offer appropriate support. This could lead to placements breaking down.
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
● Staff told us that they were unable to fully support a person who lived there, because they didn't understand the needs or triggers which may cause behaviours which challenge. One staff member said ''[name] has completely taken over the service and other people are suffering.''

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
●There had been a lack of effective governance which meant that areas of concern had not been addressed even though the provider had identified the concerns themselves.
●The management were unclear about their roles in relation to responsibility and accountability. Senior managers made decisions about the service without fully consulting the registered manager who was responsible for the service and people living there.
●The provider's own quality audit was comprehensive. The audit identified that there were areas of concern and had rated the service as inadequate. Since the audit was carried out in May 2019, there is no evidence that any actions have been taken to improve on the findings.

This is a breach Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●There was no evidence that people were involved in decisions about the service or the support that they received.
● Staff told us that they were not consulted about people using the service and did not have any involvement regarding assessment with new placements.

Continuous learning and improving care
●There had been a failure to learn from incidents. Although there was a system to review incidents, effective action was not always taken to prevent the same thing from happening again.
●On several incident reports we could see that various forms of physical and chemical restraint had been used. There were clear triggers to the incident and yet this had not been identified by the registered manager and staff had not received guidance on how to improve their practices and reduce the need for restraints to be used.

Working in partnership with others
● The service was working with the Local Authority Quality team who had identified a range of issues that were of concern during a recent quality audit.
●There was a social worker who was supporting the service with one person. This included updating and improving risk assessments to keep people safe from avoidable harm.

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 9 HSCA RA Regulations 2014 Person-centred care People were not assessed for the service and there was no consideration if a person's needs could be met prior to their placement.

The enforcement action we took:

Letter of intent was sent and consideration being given to NoP/NoD being served.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not adequately monitor the service. Errors were made in medication and staff weren't trained to offer appropriate care and support to people living at the service.

The enforcement action we took:

Letter of intent was sent and consideration being given to NoP/NoD being served.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Management did not have appropriate oversight in monitoring or managing the service which put people at risk.

The enforcement action we took:

Letter of intent was sent and consideration being given to NoP/NoD being served.