Heathcotes Care Limited

Heathcotes (Sheffield)

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good

Summary of findings

Overall summary

We undertook a focused in inspection on the 20 September 2016. There had been some significant incidents reported by the registered provider so we wanted to check people living at the service were safe. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example where a person who uses the service experiences a serious injury or there has been an incident involving the police. We had also received some concerns from members of the public about the service. This was an unannounced inspection which meant the staff and provider did not know we would be visiting.

Heathcotes-Sheffield is a care service that provides care for up to 16 people. The service consists of two purpose built houses, one called Norton House and the other Woodseats House. At the time of our inspection ten people were living at the service; two of those people were away on holiday. People living at the service had complex needs and some had behaviour that could challenge.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection on the 14 December 2015, by selecting the 'all reports' link for 'Heathcotes – Sheffield' on our website at www.cqc.org.uk.

There was a manager at the service who was registered with CQC. 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 and associated Regulations about how the service is run.

During the inspection we were not able to speak with some people using the service because we were unable to communicate verbally with them in a meaningful way. Staff were respectful and treated people in a caring and supportive way.

Three people we spoken with did not express any concerns about their safety. One person told us they went to their room if people started shouting at each other. Another person told us they felt 'safe' and they would speak with staff if they had any worries or concerns. They thought the staff were 'brilliant' and really supportive.

Staff had received training in non-abusive psychological and physical intervention (NAPPI) to enable them to support people appropriately.

Staff told us they had undertaken safeguarding training and would know what to do if they witnessed any type of abuse. Staff had a good understanding about the provider's whistle blowing procedures and felt confident that senior staff would listen.

We looked at the communal areas and spoke with staff about plans to reduce risks to people with a known

history of self-harm. We saw people at risk were supervised during daylight hours on a one-to-one basis with hourly checks overnight.

We saw each person's risk assessment and support plan showed how people may behave when they were well or when they may becoming unwell. Support plans gave guidance to staff in how they should respond to promote well-being and how they should react to de-escalate increasing agitation and anxiety.

Our scrutiny of support plans indicated the risk assessment processes and staff actions were successful in minimising the risks to people, other service users, the staff and public.

Whilst not observing the administration of medicines we looked at the medication administration records MAR charts for five people. We saw the medication administration records (MAR) sheet was complete and contained no gaps in signatures for the administration of oral medicines. However we saw the recording of the application of creams and lotions was less well recorded. We shared this information with the registered manager.

Whilst we saw 'as necessary' (PRN) protocols existed we found some were incomplete, some were misleading and some PRN prescriptions were not supported by a protocol. A protocol is to guide staff how to administer those medicines safely and consistently. For example, how the person communicated they were in pain which could be for example by facial expression. We spoke with the registered manager who assured us that the protocols would be reviewed.

We saw evidence that staff were following the providers policies and procedures on safeguarding people's finances.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People spoken with did not express any worries or concerns about their safety. From our observations we did not identify any concerns regarding the safeguarding of people who used the service.

We saw each person's risk assessment and support plan showed how people may behave when they were well or when they may becoming unwell.

Support plans gave guidance to staff in how they should respond to promote well-being and how they should react to de-escalate increasing agitation

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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.

This inspection took place on 20 September 2016. The inspection was unannounced, which meant the staff and provider did not know we would be visiting. The inspection was led by an adult social care inspector who was accompanied by a specialist advisor. The specialist advisor was experienced in caring for people with mental health issues.

Before our inspection, we reviewed the information we held about the service. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example where a person who uses the service experiences a serious injury. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was returned as requested.

We used a number of different methods to help us understand the experiences of people who lived in the service. We spent time observing the daily life in the service including the care and support being delivered. We were not able to speak with some people using the service because we were unable to communicate verbally with them in a meaningful way. Three people spoken with were able to share their experience of living at the service. We also spoke with the provider's regional manager, the registered manager, the assistant manager, two team leaders and two support workers. We also spoke with an occupational therapist and a clinical psychologist who were employed by the provider. We looked around different areas of the service; the communal areas, bathroom, toilets, storage rooms and with their permission where able, some people's bedrooms. We reviewed a range of records including the following: four people's support plans, medication administration records, financial transaction records and records relating to incidents.

Good

Is the service safe?

Our findings

People spoken with did not express any worries or concerns about their safety. From our observations we did not identify any concerns regarding the safeguarding of people who used the service. One person told us they would speak with staff if they had any worries or concerns. They told us they would just go to their room or go out and have a cigarette if people started shouting in the house they lived in. Another person told us they felt 'safe' and that the staff working at the service were 'brilliant' and very supportive.

Staff had received training in non-abusive psychological and physical intervention (NAPPI) to enable them to support people appropriately.

Staff told us they had undertaken safeguarding training and would know what to do if they witnessed any type of abuse. Staff had a good understanding about the provider's whistle blowing procedures and felt confident that senior staff would listen.

Some people living at the service went out on their own, whilst others were supported by one or two staff. During the inspection we observed one person telling staff they were going out and they were taking their phone with them if they needed to contact them. We saw another person waiting for a person to return from going out with two support workers so they could be supported to go out shopping.

We reviewed four people's support plans. Support plans demonstrated risks assessments formed the foundation upon which the support plan was constructed. Risk assessments showed how harm may come to the individual or where the actions of a person may be a risk to others. We saw some people had been identified as having the potential to cause harm to others because of challenging behaviour. People's support plans identified what staff should do to protect other people either in the home or whilst in the community. We saw support plans recorded when the police had been involved in incidents, where there was damage to property, or others had been injured. We tracked evidence of untoward behaviour and how staff responded, in daily records, incident reports, behaviour records and medicine administration records (MAR). We saw evidence of a thorough record of events which led to the production of a reflective plan in caring for people. For example, one person had been found to be at risk of causing harm to peers and carers from throwing crockery when their mental health status declined. The support plan showed the risk assessment had been modified to provide the person with lightweight plastic cups and mugs to mitigate the risk. We saw no further evidence of harm to other people since the change to the risk assessment.

We saw each person's risk assessment and support plan showed how people may behave when they were well or when they may becoming unwell. Support plans gave guidance to staff in how they should respond to promote well-being and how they should react to de-escalate increasing agitation and anxiety.

We saw evidence in support plans of people causing harm to themselves with ligatures. We examined support plans along with our observations of the environment. We looked in a room in which a person at risk spent time in private without direct supervision by staff. We looked at the communal areas and spoke with staff about plans to reduce risks to people with a known history of self-harm. We saw people at risk

were supervised during daylight hours on a one-to-one basis with hourly checks overnight. We saw people at risk were denied access to common items which may be used as a ligature. We did not find any obvious ligature points during the tour of the building. We saw anti-ligature systems were installed in the home. For example anti-ligature curtain rails were fitted with fixings designed to release by magnet.

We saw the service used antecedent-behaviour-consequence (ABC) charts as a direct observational tool to collect information about events regarding untoward behaviours. We saw staff recorded their observations that had occurred before the behaviour was exhibited which included any triggers, signs of distress or environmental information. We saw the behavioural outburst was described and what happened immediately after. We also saw the time of the incident was recorded. We saw the outcome of repeated recordings had shown staff that one person was more likely to have an outburst at a particular time of day which had enabled staff to plan social activities and outings into the community more beneficially. We noted on one occasion where the behaviour was a result of a staff comment which caused an immediate outburst of behaviour. We saw the registered manager had spoken with the staff member to ensure the trigger for the behaviour was not repeated. Our discussion with the registered manager demonstrated the service learned from mistakes and used these to improve the quality of care.

We saw evidence of risk assessments regarding people's general health needs. For example one person was found to be increasing their weight. We saw the support plan recorded how the person intended to reduce their weight and how they required staff to help them do so. We saw evidence of staff helping the person to construct an appropriate shopping list along with discussions about what foods were beneficial to aid weight loss. We also saw the person had enrolled in a weight management programme with staff giving encouragement for the person to regularly attend.

Our scrutiny of support plans indicated the risk assessment processes and staff actions were successful in minimising the risks to people, other service users, the staff and public.

Whilst not observing the administration of medicines we looked at the medication administration records MAR charts for five people. We saw the medication administration records (MAR) sheet was complete and contained no gaps in signatures for the administration of oral medicines. However we saw the recording of the application of creams and lotions was less well recorded. We saw any known allergies were recorded. We saw evidence people were referred to their doctor when issues in relation to their medication arose.

We reviewed the arrangements in place to manage controlled drugs. Controlled drugs are prescription medicines controlled under the Misuse of Drugs legislation, which means there are specific instructions about how those drugs are stored and dealt with. We saw that controlled drugs were being stored correctly. We looked at the controlled drugs records and found them to be in good order.

Whilst we saw 'as necessary' (PRN) protocols existed we found some were incomplete, some were misleading and some PRN prescriptions were not supported by a protocol. A protocol is to guide staff how to administer those medicines safely and consistently. For example, how the person communicated they were in pain which could be for example by facial expression. We saw one person was prescribed Procyclidine 5mgs PRN to a maximum of one tablet daily. The prescription was not supported by a PRN protocol. We saw the medicine had been administered on four occasions in the four days preceding our inspection. We spoke with a team leader who told us the medicine was administered for agitation and the record on the reverse of the MAR sheet recorded the reason for administration as agitation. Procyclidine is an anticholinergic drug used principally for the treatment of drug-induced parkinsonism (parkinsonism is an umbrella term that describes many conditions which share some of the symptoms of Parkinson's). The person was also prescribed Zuclopenthixol 10mgs three times a day and Quetiapine100mgs twice a day,

both of which may induce parkinsonism. We spoke with the person and asked if they knew why they had been prescribed Procyclidine and they told us it was "for tremors and shaking caused by some of my medicines". Our evidence suggested some medicines may have been administered inappropriately. We spoke with the registered manager who immediately arranged for a protocol to be produced.

We looked specifically for the use of antipsychotic, anxiolytic or antidepressant medicines as interventions for challenging behaviours. We found functional analysis had taken place to identify what appeared to trigger untoward behaviours and trends in behaviour to enable staff to de-escalate situations, commonly without the need for PRN medicines.

Some people living at the service needed support managing their monies. We saw evidence that staff were following the providers policies and procedures on safeguarding people's finances.