Heathcotes Care Limited

Heathcotes Chesterfield (Pennine House)

Inspection report

Pennine House
Cuttholme Way
Chesterfield
Derbyshire
S40 4WG

Website: www.heathcotes.net

Date of inspection visit:
29 November 2018

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08 January 2019

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Heathcotes Chesterfield (Pennine House) on 29 November 2018. It was completed by two inspectors. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection on 16, 24 and 29 August 2018 had been made. The team inspected the service against two of the five questions we ask about services: is the service well led and safe because the provider was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect these areas. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the provider demonstrated to us that improvements had been made, and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Heathcotes Chesterfield (Pennine House) is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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.

There was a manager in post who was in the process of completing their registration with us. 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.

People were not always protected from potential harm or abuse because one person was restricted in their home without legal authority. The provider had not ensured that they were always supporting people in a lawful way to safeguard them. Risk was not always fully assessed, reviewed and managed to ensure that people were safe and that lessons were learnt when things went wrong. Staff did not always have the training and competence to support people to minimise the risk of harm to themselves or others. Medicines were not always managed in line with national guidance.

The provider's own quality audits had recognised the issues with risk and training; however, no immediate action had been taken to protect people, nor to provide additional support to the manager and team at the home.

There had been improvements in providing a consistent staff team to support people. Staffing was planned around individual need and included having additional staff available to support people to go out when they chose to. Safe recruitment procedures were followed.

The manager supported staff and people within the home. Staff felt that they could raise any concerns with them. There were staff meetings and supervisions in place to support them.

The provider had worked with partner organisations to make improvements and was clear about their continued development points to improve the service. They ensured that we were notified of significant events in line with their registration.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not always protected from harm or abuse in line with legal requirements. Risk was not always fully assessed or reviewed to keep people safe. Medicines were not always managed in line with national guidance. There were enough staff to meet people's needs and safe recruitment procedures. Infection control processes were embedded.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality improvement systems were not always effective in responding to issues and concerns highlighted. People and staff felt supported by the manager. Partnership work was established to support the service to improve.

Heathcotes Chesterfield (Pennine House)

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 29 November 2018 and was unannounced.

We used information that was shared with us by commissioners of the service to assist us to plan our inspection. We also used information we held about the home which included notifications that they sent us. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. However, we ensured that the provider had the opportunity to do this during the inspection visit.

We used a range of different methods to help us understand people's experiences. We spoke with three people who lived at the home about the support they received. As some of the people would find it distressing to be asked about this, we also we observed the interaction between people and the staff who supported them in communal areas throughout the inspection visit.

We spoke with the manager and a head of service, one senior care staff and three care staff. We also spoke with a visiting healthcare professional. We reviewed care plans for three people to check they were accurate and up to date. We also looked at medicines administration records and reviewed systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. These included accidents and incidents analysis and quality audits. We asked the manager to send us additional information including staff training records and these were sent in the agreed timeframe.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found that risk was not always managed to protect people from harm, and there was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found that some improvements had been made but that other improvements were still required.
At our last inspection we identified that risk was not always fully identified. We were concerned that one person had been stopped from smoking after a certain time of night and that this was the cause of an increase in behaviours that challenged from them. At this inspection, we found that this remained an issue. One member of staff told us that there was a new agreement in place where the person managed their own set number of cigarettes per day. If they ran out after this they could have one every forty-five minutes. When we reviewed incidents of behaviours we found that several were associated with when and how the person could smoke. We asked staff what the arrangements for the person to smoke were and received inconsistent information. There was no written guidance for staff to follow and no evidence that this arrangement had been made with the consent of the person. This had resulted in increased risk of staff not supporting the person effectively during periods when their behaviour could cause harm to themselves or others.

Lessons were not always learnt from when things went wrong. Behavioural incidents were not always fully reviewed to assess and mitigate the risk to protect people from harm. For example, when one person had asked to have a bath after midnight the incident report states, 'Explained bathroom gets locked at 22:00 until 6:00'. When we spoke with the manager about this they said that this was wrong and the person should not have been stopped from taking a bath. However, when they had reviewed this incident, they had not recorded this as a trigger or stated what action would be taken to ensure that staff did not restrict the person in this way again. They did not review or alter the person's risk assessments. In addition, when there was an increase in behaviours no additional review or analysis took place to try to identify the triggers.

When we reviewed staff training to ensure they were equipped to competently support people we found that over one third of staff had not completed mental health awareness training. Furthermore, staff told us that the training provided was a basic introduction. All staff we spoke with identified mental health issues as the primary support that people needed from them. When we spoke with staff and looked at people's care plans we saw that people had a range of complex mental health support needs. One health professional told us that the staff team had provided a caring environment which made people feel safe. They said, "They are doing the best they can with limited resources but could do with more support and training".

Medicines were not always managed to ensure that people received them as required. One person's medicine was prescribed to be taken daily. However, it was administered 'as required', or PRN and the manager had handwritten 'PRN' onto the Medicines Administration Record (MAR). When we alerted staff to this they telephoned the health professional who prescribed it and informed us that they were told it was to be taken each day. After the inspection we were informed that the provider had followed this up and that the medicine should be PRN and an email confirmation of this was sent. The management of this medicine was not in line with national guidance. Another person refused a medicine which they were prescribed daily. The provider had not notified the prescriber or requested a health review to ensure that there was no impact

on the health and wellbeing of the person. Again, this did not meet national guidance.

This was an ongoing breach in Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

People were not always safeguarded from harm because they were deprived of their liberty without lawful authority. One person had been assessed as sometimes behaving in a way which could cause themselves or others harm. Staff were given guidance to support the person when they behaved in this way and one of the actions they could take was to physically restrain them. The provider had applied for legal authority to take this action. However, this had not been authorised by the relevant authority. Staff had continued to restrain the person for two months after this. They were physically restrained fifteen times during eight separate incidents of behaviours that challenged. The reasons for these restraints included the person attempting to leave the property. When we spoke with staff about this they told us that they felt this action was in the person's best interest. They did not agree with the outcome of the legal authorisation application. When we spoke with the manager about this they told us that they were working on new assessments for the person and had discussed it with other health and social care professionals. However, no immediate action had been taken by the provider to ensure that staff were working within the law. This meant they had not safeguarded the person from potential harm or abuse.

This is a breach in Regulation 13 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

At our last inspection we found there were not always sufficient numbers of staff deployed to meet people's needs safely, and there was a breach of Regulation 18 (1) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found that the required improvements had been made and there was no longer a breach of this regulation.

Staffing levels were planned around individual need. This included additional resources to ensure that people could be provided with the correct assessed number of staff required to support them safely at home and when they went out. For example, some people required two staff to keep them safe when they went out. At our last inspection we raised concerns about staff working excessive hours and at this inspection this had been resolved. The provider had appointed new staff and was continuing to recruit. Staff told us that there were enough staff to be able to support people and we saw that they had ample time to spend with people on the day of inspection. For example, there were staff available to support people to prepare meals, to go out shopping and for a meal and to have fun putting the Christmas decorations up together. The manager told us that they planned the staffing to be flexible to meet people's needs. There were additional staff available throughout the day to provide people with one to one time when required rather than having set times for this support. This demonstrated to us that the provider was responsive to people's needs when planning staffing levels and the records we reviewed confirmed this.

Safe recruitment procedures had been followed. Staff told us that police checks had been completed and references given of their character before they started work. Records we reviewed confirmed this.

The home was clean and well presented. There were cleaning rotas in place to ensure a good level of hygiene was maintained to protect people from infection.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found good governance systems were not always in place, and there was a breach of Regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found that some improvements had been made but that improvements were still required.

The systems in place to monitor and improve the service were not always effective in doing so. An internal audit was completed by the provider's compliance team on 19 November 2018. It recognised and reported some of the same issues we had identified at this inspection. For example, one recommendation stated, 'Use of physical intervention – I would suggest this is reviewed Restrictions on cigarettes – needed.' We saw that no action had been taken as a consequence of this recommendation.

This report also recognised that the legal authorisation to restrict one person had not been granted. There were no recommendations about this to challenge the decision. It also reviewed three incident reports of behaviours that challenged and restraints and stated for the one on 15 October 2018 that, 'Manager review is not looking at options on how to prevent those behaviours from escalating again.' Therefore, although the provider's audit recognised the risk about how the behaviours were being managed no action was taken to support the team in the home. Despite these findings this audit rated the home as good. Therefore, the audit was not effective in assessing the impact of the risk identified or in supporting the manager to take action to remedy them.

This was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a manager in place who had provided stability since the last inspection and they were in the process of completing their registration with us. 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.

Staff felt supported by the manager and that they were approachable. One member of staff said, "I love working here and have been really well supported". They told us that they received regular supervisions and staff meetings and were confident that the manager would respond to any concerns raised.

We saw that the manager knew people well and spent time throughout the day with them. They told us they had focussed on stabilising the staffing situation and providing a safe, caring environment for people. We saw that this had a positive impact on some of the people who lived at the home who were more settled with less incidents of anxiety or behaviours that challenged. For example, one person had progressed to the point that they were planning to move to more independent living in the near future.

The provider had worked closely with commissioners to meet action points to improve the service for people. For example, there was now a more systematic approach to new referrals, including a detailed

admission process that considered how the people who already lived at the home would get on with potential new people. There were ongoing action points relating to staff training and record keeping which the manager was prioritising.

We received notifications of incidents in line with the provider's registration which meant that we could check that relevant action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always provided with 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 protected from abuse and improper treatment

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 17 HSCA RA Regulations 2014 Good governance Systems or processes were not always effectively operated to ensure good governance and quality improvement.

The enforcement action we took:

We issued a warning notice.