Heathcotes Care Limited

Heathcotes Chesterfield (Loundsley House)

Inspection report

Loundsley House
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Chesterfield
Derbyshire
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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 8 people. There were 7 people living at the home at the time of our inspection.

People's experience of using this service and what we found
The outcomes for people using the service didn't reflect the principles and values of Registering the Right Support. Choice and control were not central to support provided and some people had not consented to interventions used to protect them. The least restrictive options were not always used to protect people from harm. Risk was not managed to ensure staff received up to date guidance in supporting people. When incidents occurred they were not fully reviewed to learn from them and reduce the risk of recurrence. Staff had not received adequate training to support people with complex health needs.

Assessments were not always in line with best practise guidance and some plans were not in place to direct staff; for example, how to support people with their diet in a positive way. This increased the risk that they were not always receiving care and support which met their preferences. Some people had communication systems in place and others were being developed although it was taking a prolonged time.

The provider did not have adequate oversight of the home despite an internal review noting there were significant improvements required. Staff were working consecutive days without a break leading to low morale. They did not have confidence in the responsiveness of the provider. There had been limited improvements since our last inspection.

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 requires improvement (published 7 March 2019)

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement:
We have identified breaches in relation to risk management, safeguarding people from harm, staffing levels and support, consent to care and good governance at this inspection.

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
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

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.

Inspection team
The inspection was completed by one inspector and an assistant inspector.

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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used information we held about the service which included notifications that they sent us to plan this inspection. We also used the completed 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. We used all of this information to plan our inspection.

During the inspection
We spoke with people who lived at the home. People had varying levels of communication and some chose not to speak with us in any detail. Therefore, we also observed staff support and interaction with people in

communal areas. We spoke with one person's relatives about their experience of the care provided. We also spoke with seven members of staff including the manager and the area manager.

We reviewed a range of records. These included care records and incident forms for all seven people and three people's medication records. We looked at two staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, including audits, were reviewed.

After the inspection
We spoke with health and social care professionals who work closely with the people who lived in the home, including feeding back about some of the concerns we found at the inspection.
We continued to seek clarification from the provider to validate evidence found. We looked at training data, incident reports 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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Preventing and controlling infection
• Some people could behave in ways which may cause harm to themselves or others. At times this meant staff needed to use physical restraint to protect the person or others from harm. The use of this intervention was not always fully reviewed and followed up to ensure it was the least restrictive action which could have been taken to keep people safe.
• Staff and other professionals we spoke with told us some people's behaviours were reduced when they were supported by certain staff. This had not been reviewed by the provider to consider how this interaction could be assessed to provide guidance to other staff about how to work with those people in a similar way.
• Some people's plans were not reviewed after incidents of harm to ensure staff had up to date guidance around supporting them. For example, one person's plan did not mention any physical intervention which could be used to support them to manage their behaviour. However over a two-month period, five incidents had resulted in staff using this. Professional guidance had also been given and this had not been incorporated into their plan. This failure to fully review incidents and provide staff with up to date guidance on supporting people increased the risk of harm.
• The environment was not sufficiently clean to control and prevent infection. Areas of the home were unclean, untidy and required refurbishment.
The provider's failure to provide safe care and treatment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• Physical intervention, including restraint, was used at times by staff to protect some people from harm. This can only be used if it has been assessed as required in the person's best interest. We found incidents when physical intervention were used in emergency situations. However, the person's care plan was not updated afterwards to guide staff and some significant incidents were not referred to the safeguarding authority.
• Other incidents were not fully reviewed to ensure the risk of ongoing harm was reduced. For example, an action was for staff to receive additional training which wasn't provided in a timely manner before other incidents occurred.
• Concerns raised about staff were not always fully reviewed and managed to ensure they understood their responsibilities to protect people from harm. For example, some concerns raised about staff interaction with people they supported were not managed through safeguarding or disciplinary processes.
• The analysis of the use of physical intervention was not sufficient to ensure it was the least restrictive option available on all occasions.

The provider's failure to protect people from abuse and improper treatment was a was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• At our last inspection we found staff worked excessive hours without planned breaks. At this inspection we found this had continued.
• Some staff had worked for consecutive days of over one week with some of those days being twelve to fourteen hours long. One member of staff had worked for nine consecutive days with two sleepovers.
• Due to the shortage of staff the provider had reduced the number working at night and had one member of staff sleeping over. However, they were asked to do this on sofas in a communal area and staff told us they did not feel this was adequate rest to be ready for the next day's work.
• Although the provider was recruiting new staff and asked current staff to work extra to provide consistency for people they had not risk assessed the impact excessive hours could have on staff wellbeing and their ability to provide consistent, patient support to people with complex needs.
The provider's failure to ensure there were enough, suitably qualified staff was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider was following safe recruitment practises.

Using medicines safely
• Individual arrangements were in place to support people to manage their medicines when this was required.
• Medicines systems were organised, and people were receiving their medicines when they should. The provider was following safe protocols for the receipt, storage, administration and disposal of medicines.
• When people were prescribed medicines to take 'as required', there was guidance in place to support staff to know when this was needed.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
• Staff were not always provided with sufficient training to enable them to support people safely.
• One person had moved into the home who had specific support requirements. Only half of the staff had completed training in their health needs. Some of the staff who had done this course told us it was not adequate or detailed enough to guide them in the person's specific, complex needs. This put the person at increased risk of harm.
• After some incidents which required staff to use physical intervention to keep people safe the action to be taken to reduce the risk was for staff to be provided with specific training to meet the person's needs; however, this was not provided in a timely manner and additional incidents occurred. This meant the provider did not ensure staff were sufficiently trained to meet people's needs and keep them safe.
• There were records which demonstrated staff had not fully followed people's plans when managing incidents. Although we were told senior staff had conversations with other staff there were no records of this and no additional training was given.
The provider's failure to ensure that staff received appropriate support, training and supervision was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People did not always have thorough assessments and plans in place to ensure they received good support to maintain their health and wellbeing.
• One person's assessment did not include which professionals to contact if they were unwell. It did not describe all the ways this could be shown; for example, certain behaviours which the person had already demonstrated. The care plans had also not been reviewed to ensure staff had current guidance in line with national guidelines.
• Another person required support around their diet and there were records which demonstrated this had caused them anxiety and distress. However, there was not specific guidance for staff to help the person to manage this anxiety and we saw that this had on occasion escalated to physical intervention by staff. This lack of assessment and guidance for staff increased the risk of harm to the person and did not ensure they received the least restrictive support in line with national guidance.
The provider's failure to provide safe care and treatment in line with national guidance was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed.
When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• One person was supported with their health and behaviour needs in a manner which had not been assessed, was not in their care plan and they had not consented to despite having capacity to do so. Only after a significant incident of harm was their care plan reviewed and agreed with the person.
• Other people were not able to consent to some decisions and we found capacity assessments were completed in these instances and decisions made in their best interest with other professionals and family members.
• Any conditions in DoLS were being met in line with legal requirements.
We recommend the provider ensures they are meeting the requirements of the MCA and ensuring all people who live at the home have consented to their care.

Adapting service, design and decoration to meet people's needs
• People were supported in an environment suitable for their needs and which promoted independence.
• People were supported to decorate their own bedrooms to meet their personal tastes. One person showed us their bedroom and told us they were happy to have been able to choose the decorations.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question had deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• Staff we spoke with told us how much they cared for the people they supported, and we observed caring interaction. However, they also said they did not feel people were always cared for as well as they could be due to staff shortages. One member of staff said, "Morale is low at the moment. A lot of staff have left and at times we feel like we are running around and not spending time with people."
• Some staff told us they felt other staff were less equipped to support people who could behave in a way which caused harm to themselves or others. For example, they explained some staff seemed scared while others could raise their voice and be 'strict'. We shared this information with the home manager and with other professionals after the inspection visit.

Respecting and promoting people's privacy, dignity and independence
• People had their own rooms which were decorated to their taste. We saw some people chose to spend time in their rooms and staff respected this as their private space, including knocking before entering.
• Staff described actions they took to protect people's privacy; for example, ensuring one person had a towel around them if they chose to undress in a communal area.
• Important relationships were prioritised, and some families visited on a regular basis. One relative told us, "We think [Name] is happy here and the staff are supportive. They communicate well with us."

Supporting people to express their views and be involved in making decisions about their care
• People were involved in making decisions about their care and when they were unable to express this for themselves staff communicated with families and other professionals who supported the people to ensure care was planned to meet their preferences. However, we found this was not always reflected in care plans.
• We observed staff offer people choice during our visit. This included how they wanted to spend the day, what meals they wanted and when they got up.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• People's current care needs, and preferences were not always included in their care plans which increased the risk of them not receiving appropriate support.

• Care needs were not always reviewed after incidents to ensure the learning from them was incorporated; for example, incidents which had resulted in staff physically intervening were not always reviewed in the care plan to offer consistent guidance to staff.

• Staff we spoke with told us certain staff had better interaction with particular people, resulting in less behavioural incidents. This interaction had not been observed and used to plan people's support to ensure they received a consistent approach. Similarly, one professional told us that other opportunities to observe experienced staff interacting with one person had not been taken up to coach other staff.

• People had different levels of activities organised with some people having regular daily education arrangements at school and college. However, other people had limited organised activities and found it more difficult to engage and participate in things outside of the home.

• Some staff told us they were concerned about some people's isolation. One member of staff said, "It can be difficult to get people motivated but I do think we should be doing more to get them out." Another member of staff said, "People are becoming more isolated and some don't leave their room often. I think we could do more together in the house as a group, but it hasn't happened for ages."

• On the day of the inspection visit some people spent the majority of their time in their rooms. The manager told us they were working with other professionals to help people to make more choices about going out with communication aids. However, one professional told us there was a delay in implementing this as the training had been given two months previously.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's communication needs were assessed, to show how information should be shared with them. For example, for one person had specific words and phrases they needed staff to use to explain what was happening to them. Others used sign language and staff understood which signs they used and what they meant.

• Information was shared in an accessible manner, using pictures and symbols to help explain it for some people. For example, the complaints procedure included photographs of the staff people could speak with if

they had any concerns.

Improving care quality in response to complaints or concerns
• Information about complaints was shared with people and relatives.
• Any complaints received were managed in line with the providers procedure.

End of life care and support
• People's wishes about the care they would like at the end of their lives had been considered when planning their care. However, there was no one at this stage in their life.

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 requires improvement. At this inspection this key question has 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; Continuous learning and improving care
• The provider had not ensured staff were trained and supported to manage people's needs when they moved into the home. The provider had committed to ensuring this was completed after incidents in some of their other homes. They had also stated the quality team would complete reviews of incidents and behaviour management. This had not occurred and there had been minimal review of incidents within the home by the provider.
• Staff were working excessive hours without risk management systems put in place. This included being required to sleep in without adequate facilities to do so, which was not in line with government guidance. In addition, it meant people were not able to access communal areas of their home when it as used for this purpose.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Some staff were not given the opportunity to reflect on their responsibilities to manage risk and protect people from harm because incidents were not always fully reviewed to understand how they could have been managed differently.
• Some staff were not confident in raising their concerns about the home with managers. Some said they had previously raised concerns and no action had been taken about them. All staff who worked regularly at the home told us they wouldn't recommend it as a place to live or work.
• We saw staff meetings took place regularly and minutes of the meetings were kept and shared with staff. However, again staff were not optimistic about the outcome of some of the discussions which took place. One member of staff said, "The meetings are not really beneficial because a lot gets said that doesn't get acted on."
• We found that some items which had been discussed in meetings remained a concern. For example, it was recorded that cleaning standards were not being maintained and we also found this. In April 2019 there was a discussion about staff managing one person's food better, so it didn't lead to incidents of behaviour; however, we saw this had occurred again.
• There were regular opportunities for people who lived at the service to feedback about their care. However, the delay in implementing communication systems meant some people couldn't do this meaningfully.
The provider's failure to always manage risk and respond and act on feedback meant they were in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
• Other professionals and the relative we spoke with informed us the provider communicated with them when accidents or incidents occurred.
• The provider had submitted statutory notifications as required. This is information about events occurring at the service, which the service is legally required to notify CQC about.

Working in partnership with others
• There were relationships with local health and social care professionals however their advice was not always recorded and shared with staff to ensure people were protected from harm.

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 because risk management was not sufficient.

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 harm using the least restrictive options available.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to meet people's needs safely and they were not provided with the training they required to keep people safe.

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 There was not sufficient provider oversight to ensure people were protected from the risk of harm.

The enforcement action we took:

We sent a warning notice asking the provider to make specific improvements in a set timescale.