Heathcotes Care Limited

Heathcotes (Moorgreen)

Inspection report

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected the service on 24 November and 12 December 2016. The inspection was unannounced. Heathcotes (Moorgreen) provides short term treatment and support for up to eight people who have a diagnosis of personality disorder. The service was relatively new having only been registered since August 2016 and on the day of our visits three people were using the service.

The service had a registered manager in place 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.

People were not protected from risks associated with the environment. Risks in relation to people's care and support were not assessed or planned for appropriately. Staff did not always follow guidance to minimise risks to people.

There was a risk that people may not receive their medicines as prescribed and medicines were not stored or managed safely.

Staff did not always receive suitable training or support to enable them carry out their duties effectively and meet people's complex needs. There were not enough staff to provide care and support to people safely. Safe recruitment practices were not always followed.

People who lacked the capacity to make certain decisions were not protected under the Mental Capacity Act 2005. However, where people had capacity they were enabled to make choices about their care and support.

People were at risk of receiving inconsistent support as care plans contained contradictory information and staff did not always follow guidance in care plans. People did not always receive the support they required as staff we not always available to meet their needs.

People were supported to eat and drink enough. People had access to healthcare and people's health needs were monitored and responded to. Staff were kind and caring and treated people with respect and people's rights to privacy and dignity were promoted and upheld.

People were supported to raise issues and concerns and there were systems in place to respond to concerns and complaints. People were involved in giving their views on how the service was run.

Where possible people were involved in planning their care and support, staff knew people's individual preferences. People were supported to maintain relationships with people who were important to them.

Governance systems in place to ensure the safe and effective running of the service were not adequate and this put people at significant risk of harm. Timely action was not taken by the provider in response to known issues which resulted in negative outcomes for people who used the service. Management structures in place at Heathcotes (Moorgreen) were not effective and appropriate policies and procedures were not always in place.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, staffing and good governance.

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

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?

Inadequate

The service was not safe.

People were not protected from risks associated with the environment.

Risks in relation to people's care and support were not assessed or planned for appropriately. Staff did not always follow guidance to minimise risks to people.

There was a risk that people may not receive their medicines as prescribed and medicines were not stored or managed safely.

There were not always enough staff to provide care and support to people when they needed it.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always receive suitable training or support to enable them carry out their duties effectively and meet people's individual needs.

People who lacked the capacity to make certain decisions were not protected under the Mental Capacity Act 2005. Where people had capacity they were enabled to make choices about their care and support.

People were supported to eat and drink enough. People had access to healthcare and their health needs were monitored and responded to.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with respect.

People were enabled to have control over their lives and were supported to be as independent as possible.

People's rights to privacy and dignity were promoted and respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were at risk of receiving inconsistent support as care plans contained contradictory information and staff did not always follow guidance in care plans.

People did not always receive the support they required as staff were not always available to meet their needs.

People were supported to maintain relationships with people who were important to them.

People were supported to raise issues and concerns and there were systems in place to respond to concerns and complaints.

Is the service well-led?

Inadequate

Governance systems in place to ensure the safe and effective running of the service were not adequate and this placed people at risk of harm.

Timely action was not taken in response to known issues and this resulted in negative outcomes for people who used the service.

Management structures in place were not effective and policies and procedures were not always in place as required.

People and staff were involved in giving their views on how the service was run.

Heathcotes (Moorgreen)

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 was undertaken to explore information received about the service, to check 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 and to provide a rating for the service under the Care Act 2014.

We inspected the service on 24 November and 13 December 2016. The inspection was unannounced and the inspection team consisted of two inspectors, one from the adult social care inspection team and one from the mental health inspection team. A specialist mental health advisor also took part in the inspection.

Prior to our inspection we reviewed information we held about the service. This included information received from the service and other sources and statutory notifications. A notification is information about important events which the provider is required to send us by law.

During our visit to Heathcotes (Moorgreen) we spoke at length with one person who used the service and briefly with another person. We also spoke at length with two members of care staff and briefly with a further three, a team leader, the service manager (who was responsible for the day to day running of the service), the registered manager (who was also a regional manager), another regional manager, the consultant clinical psychologist and the occupational therapist. We looked at the care and medicines records of all three people who used the service, three staff recruitment and training records as well as a range of records relating to the running of the service including audits carried out by the management team. We also observed care and support in communal areas of the service.

Inadequate

Is the service safe?

Our findings

The service was not managed safely to minimise risks to people. People who used the service required a significant amount of support to manage serious risks to their health and wellbeing, such as self-injurious behaviours. Although some measures had been taken to restrict people's access to potentially harmful items, such as locked sharps drawers and restrictions on items that staff could bring into the building such as cans and bottles, the approach to this was not consistent. We found items in people's rooms and in other areas of the building, such as sharps, glass and batteries, that people could potentially use to harm themselves. No risk assessment had been conducted to assess the risks associated with these items and consequently the level of risk was unclear. One person had previously used an item to harm themselves and this was still freely accessible in the service. This put the person at risk of further harm. Another person was at risk of ingesting non-food items and we found that this person had unsupervised access to items such as laundry detergents which may cause harm if ingested.

No risk assessment had been conducted on the premises to assess risks specific to the client group. This meant that people were placed at potential risk of harm. For example people who used the service were at risk of applying ligatures to cause harm to themselves. We found although this had been addressed in some areas of the building with the use of anti-ligature fittings such as curtain rails there were ligature points present throughout the service. This included in people's bedrooms where people were unsupervised for lengthy periods of time. We were not provided with any evidence that these risks had been assessed and consequently no clear plans were in place to mitigate the risk.

We discussed the above risks with the management team during our visit who explained that exposure to risk was an important aspect of the therapeutic model at Heathcotes (Moorgreen) to enable people to gain insight into their actions and make progress in managing their behaviours and emotions. However this explanation did not justify the lack of proactive consideration of risks outlined above.

People were not always safeguarded from risks associated with the environment. The provider had fitted doors that were designed to ensure that people could not barricade themselves in their rooms. During our visit we saw that two of these doors had been damaged in previous incidents. A member of staff explained that these doors had not been fitted correctly which resulted in an obstruction when opening the doors from the outside. The management team also informed us that it took a significant amount of time to open the doors as they did not have access to the appropriate tools so had to do this manually. Someone had recently barricaded themselves in their room and the member of staff told us that it had taken considerable force and upwards of five minutes to access the person's room. Timely action had not been taken to eliminate this risk and consequently this placed people at risk of harm.

Robust systems were not in place to safeguard people from harm. Records showed that people who used the service were often awake and active into the early hours of the morning, however there were no formal processes for ensuring people's safety throughout the night. Whilst staff we spoke with explained how they tailored their support depending on people's mood to ensure their safety this was on an informal basis. The service manager told us, "There is nothing solid (in place for night checks), staff nip in and check people

(when they are in their rooms)." There were no risk assessments in place to address risks faced by people at night or guidance about how frequently people should be checked. We spoke with a member of staff who told us, "We do check people (at night) we just don't record it." Given the risks present in the building and in people's bedrooms this placed people at significant risk of harm.

People were at risk of scalding themselves due to hot water temperatures in some bathrooms being above the recommended safe level. Although hot water temperatures were being regularly tested action was not taken to bring water temperatures back into a safe range. For example records showed that a shower in one of the bedrooms that was in use was measured above the recommended level of 43°C for two consecutive months. This was a particular risk as the person was at known risk of burning themselves. Following our visit the registered manager informed us that they took swift action to ensure that all water temperatures were brought back within a safe range and during the second day of our visit water temperatures were within safe range.

People could not always be assured that their medicines were managed safely. We found that there were two tablets missing from one person's medicines. This was a controlled drug. Controlled drugs are types of medicines that have stricter legal controls applied to prevent misuse. This had not been identified by the management team so no action had been taken to investigate why these medicines were missing. This increased the potential for misuse of these medicines.

People were at risk of not receiving their medicines as prescribed. We found that medication administration records (MARs) had not been accurately completed to show that people had received their medicines as intended. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. There were occasions when it had been recorded on the MAR that a person had not had their medicines, however the reason for this had not been documented. One person we spoke with told us that they felt they did not always get their medicines as required.

When people were prescribed medicines to be taken as and when they required them (known as PRN) there were not always written protocols in place detailing what these medicines had been prescribed for or when they should be taken. This meant that staff did not always have clear information about when to give people these medicines. For example, one person had been prescribed medicines to relieve their anxiety, there were no details of when this medicine should be administered which put the person at risk of suffering unnecessary anxiety and upset. Despite this staff had an understanding of the process for administer these medicines and told us, "We are told to discuss with a manager the administration of any PRN medication before it is given." Following our visit the registered manager informed us that protocols for PRN medicines had been put in place as required.

People's medicines were not stored safely to ensure they were at their most effective. The temperature of the medicines room was not monitored or recorded as the thermometer had been out of use for four weeks and action had not been taken to address this. We also found the temperature of the fridge used to store medicines was not monitored and on the day of our visit it was above the recommended range. This could have had an impact on the safety of medicines and put people at risk of being given medicine that was not effective. We shared this feedback with the management team and following our visit they took action to replace the thermometer in the medicines room.

We were shown copies of monthly medicine audits that the management team undertook which identified areas for improvement; however they had not been effective in identifying all the issues found during our inspection.

All of the above information was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing levels were not always sufficient to ensure that support was provided safely. During our 24 November 2016 visit the service manager told us that the day shifts were normally staffed by four to five staff and nights were staffed by three members of staff. During our 13 December 2016 visit the service manager told us that they were facing some staffing difficulties and staffing levels had decreased to a minimum of three staff during the day and a minimum of two staff at night.

We spoke with a member of staff about night time staffing levels, they told us that two members of staff were enough, "As long as there were no incidents." We asked staff what would happen if there was an incident overnight and they told us that they would call the on call number and call around other staff members to come into the service. This system involved calling a manager who would then provide advice, go to the service or source additional staff. We reviewed notifications and found that there were two recent incidents which took place at night, one of which resulted in two members of staff leaving the building for a period of time. Records showed that only two members of staff were on shift which meant that two people who used the service were left unattended in the home. This put people at risk of harm. The on-call system was not effective in the above situation and would not be robust in the event of an emergency situation.

We were informed by one person who used the service that on some occasions only two staff had been on shift during the day. We reviewed rotas which showed that this had been the case on one day. This was below the staffing level required to provide safe support as each of the three people living at Moorgreen had one to one support for their waking hours. This placed people at risk of harm.

We also identified concerns about the competency of the staff providing support at Heathcotes (Moorgreen). Records showed that that on occasion staff from other Heathcotes services were used to cover shifts – in particular night shifts. We asked the service manager if these staff had training appropriate to the client group at Moorgreen and they told us that all Heathcotes staff went through the same training programme. We asked the service manager if they had checked what training these staff had undertaken and they informed us that they had not done so. This meant that there was a risk that staff may not have all the skills and training necessary to support people safely.

Although we were informed by the regional manager that they tried to ensure consistency of staff brought in from other services and that these staff were provided with time at the start of the shifts to read people's care plans, this did not assure us that these staff had a good understanding of the complex nature of the support needs of people living at Heathcotes (Moorgreen). This put people at risk of inconsistent, unsafe support.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not always be assured that safe recruitment practices were followed. The necessary steps to ensure people were protected from staff that may not be fit and safe to support them were not always taken in a timely manner. We saw one staff file where the member of staff had declared a previous conviction. Although there was a risk assessment in place to assess the potential impact on people who used the service this had not been put in place in a timely manner. This put people at risk of being supported by unsuitable staff. We discussed this with the registered manager who understood the importance of safe recruitment practices and assured us that risk assessments would be completed swiftly in the future. Other steps had been taken to ensure people were protected from staff that may not be fit and safe to support

them. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. We also saw that proof of identity and appropriate references had been obtained prior to employment and were retained in staff files.

There were systems and processes in place to minimise the risk of abuse and staff had received training in protecting people from abuse. One person we spoke with told us, "Sometimes staff help me to feel safe." Staff we spoke with had a good knowledge of how to recognise allegations or incidents of abuse and understood their role in reporting any concerns to the management team and escalating concerns to external agencies if needed. One member of staff we spoke with said, "I would talk to the team leader or the manager if I needed to." Another member of staff explained how they would contact the safeguarding team should they have concerns about someone's welfare. Staff were confident that any concerns they raised with the management team would be dealt with appropriately. Records showed that the management team had taken appropriate action and shared information with the local authority when it was needed.

During our inspection one person who used the service disclosed information of a concerning nature to us. We made a referral to the local authority safeguarding adult's team. The investigation had not yet concluded at the time of writing this report.

We saw records of meetings with people who used the service which showed that these were used to discuss information about staying safe. This included ensuring people were aware of the fire procedure and discussion about changes that could be made to the environment to make people feel safer. The service manager also informed us that they provided individualised support and advice to people about staying safe. For example, the staff team had recently worked with one person to develop guidance about using the internet safely.

Requires Improvement

Is the service effective?

Our findings

Staff did not have the necessary training required to support people safety. Staff had received training in techniques for working with people who communicated with their behaviour. However we found that only three staff had completed the advanced level training which was necessary to use specific types of restraint. The service manager told us, "We do not have enough people trained in level three to use some of the holds." Whilst the staff that we spoke with were clear that they should not use these types of restraint without training we saw that one person's care plan stated that this type of restraint could be used with the person in a crisis situation. This lack of training meant that it was likely that the person would not receive the support detailed in their support plan in the event of a crisis which would put them and others at risk of harm.

The service manager told us that staff were provided with an induction period when starting work at Heathcotes (Moorgreen) including training, shadowing experienced staff members and reading care plans to learn about the needs of people using the service. However one recently recruited member of staff we spoke with told us, "On my first couple of days I was given some care plans to read." We asked if they had spent time shadowing experienced staff and they told us, "No, I didn't do any shadowing." They confirmed that after reading care plans they had started supporting people. This was not an effective induction and put people who used the service at risk of receiving inconsistent, unsafe support.

Staff did not always receive adequate support or debrief following incidents. We found that there were no formal systems in place for supporting staff following serious incidents that could be potentially distressing for staff. The service manager told us, "We don't have a specific debrief, but we have an open door policy. They (staff) would go to a team leader if they needed support." We spoke with two members of staff who informed us that although they could approach a senior member of staff for support following incidents they were not routinely offered a formal debrief. One member of staff told us, "We could do with some support."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw records which showed that staff had up to date training in a number of areas including safeguarding, the Mental Capacity Act, equality and diversity and health and safety. Feedback from staff regarding the training was varied, whilst two members of staff were positive about the training they had received another staff member told us they had not had any training in personality disorders and told us, "No I haven't had any training (in personality disorder) I have researched things on the internet." One person who used the service commented, "Some of the staff are not experienced enough and don't seem to understand about personality disorder." We shared this feedback with the management team during our visit and they assured us that staff were provided with training and staff who had not yet received this would be provided with the training the following week.

In addition to the above staff received two days of dialectic behavioural therapy training prior to working

with people. This was provided by the specialist Dialectical Behaviour therapists employed by the provider. One staff member told us that this training helped them to support people and understand their requirements. A support worker said "I have just made someone's life happy because they wanted to go to the town and I was able to make that trip happen today. Having the Dialectical Behaviour Therapy (DBT) training helps me see things from the persons view and how it is important to try to meet these needs". Another member of staff we spoke with explained that the training helped them to understand and promote techniques such as 'mindfulness' to support the people who used the service. We spoke with the therapists who told us that staff also attended a skills group to build their knowledge in DBT.

The service manager told us that new staff had completed or were in the process of completing the Care Certificate. The Care Certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care.

Staff we spoke with told us they had regular supervision meetings. Records showed that staff had supervision every four to six weeks and in addition to this had one to one time with the two Dialectical Behaviour therapists who visited weekly to discuss any concerns or issues related to people who used the service. The service manager told us that they also had a system of 'instant supervision' to address performance issues within the staff team.

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 they 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are 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 were being met.

People's rights under the MCA were not protected as the principles of the act were not always correctly applied. MCA assessments and best interest decisions were not always in place as required. For example, an urgent authorisation to deprive a person of their liberty under the Deprivation of Liberty Safeguards (DoLS) had recently been granted for one person. DoLS are only granted where people are deemed lack capacity in an area of their life. However we found that no mental capacity assessments were in place for this person. We discussed this with the registered manager during our visit who informed us that mental capacity assessments would be completed for this person following our visit. During our second visit we found that there were still no mental capacity assessments in place for the person and their care plan had not been amended to include details of the person's fluctuating capacity. This did not respect the person's rights under the MCA.

Applications for DoLS had been made where appropriate to ensure that people were not being deprived of their liberty unlawfully. One person had been assessed as requiring support from staff if they went out into the community and they were not free to leave the service alone. There was an up to date DoLS authorisation in place for this person. We spoke with a member of staff who had a good understanding of the implications of the DoLS, they told us, "The staff are now legally able to persuade [person who uses the service] to stay inside or escort that person whilst they are in the community." People who used the service

also had been involved in the DoLS process and had an understanding of how this impacted upon their support. Care plans contained specific information in relation to restrictions placed on people's lives to ensure that they were the least restrictive option.

Where people had capacity they were supported to make decisions. Throughout our visit we observed staff enabling people to make informed choices and gaining their consent. People's care plans detailed how to support people to make decisions to maximise their choice and control.

People's feedback about the food provided at Heathcotes (Moorgreen) was variable. One person told us, "It's okay, it depends who has chosen it." Another person told us, "The food is very variable and all the food is bought in, there is no home cooking, however the quiche we had for lunch today whilst being bought ready-made was nice."

We found that people were supported to eat and drink enough. The service manager told us, "We have a four week rolling rota, we sit with people (who use the service) and decide each meal with them. This is reviewed when new people join or when people request a change. We have also just introduced a themed night, we had Chinese last week." The service manager also told us that people who used the service were supported to shop for food and people could then choose to get involved with food preparation with staff support. Weekly menus showed that people were provided with a wide variety of foods. We observed that people had access to frequent snacks throughout the day and were also supported to access the kitchen and help themselves to drinks. A member of staff we spoke with explained that meal times were not rigid but flexible to meet the needs of people who used the service and we saw this in practice during our visit.

People were protected from risks associated with eating and drinking. For example a member of staff told us about one person who had a food allergy, they explained how they ensured that food was prepared in different areas of the kitchen using separate utensils. There were clear details in the person's support plan relating to this including details of emergency medication.

People's nutritional needs were assessed regularly and there were support plans in place with clear details of the support people required in this area. One person required prompting and encouragement to promote healthy eating and there were plans in place relating to this.

People were supported with their day to day healthcare needs. People were given support to attend regular appointments and to get their health checked. One person told us, "When I came here my keyworker tried very hard to sort out something with my GP and (keyworker) is very good if you have a problem." People had a health action plan specifying the support they required with their health. Records showed that staff sought advice from external professionals when people's health and support needs changed. Staff also made referrals to external mental health specialist teams when advice and support was needed and we saw the advice received was included in people's support plans.

Where people had specific health care conditions care plans contained information about the condition and guidance for staff about how to respond to any changes. For example, one person had a health condition which was controlled by their diet. Their care plan identified risks associated with eating certain types of food, measures that were in place to reduce this risk and information about how to recognise that the person may be becoming unwell. We spoke with one person who told us that the staff supported them with managing their health condition. This person told us, "I have diabetes and the staff support me to keep my blood sugars stable by providing a healthy eating plan, weigh me regularly and assist me in the management of my diabetes."

People who used the service had access to a range of specialist professionals who were employed by the provider. This included a consultant psychologist and a specialist occupational therapist who attended the service two days a week to provide therapy and support to people who used the service and to provide specialist support and supervision to the staff team. We spoke with the consultant psychologist who told us that therapy sessions took place twice a week with people who used the service with staff attending at least one of these sessions. A member of staff explained to us how information from these group sessions is communicated. They said, "Whichever member of staff attends the therapy session will verbally communicate to the rest of the team problems or issues which have happened." The service manager also told us that they were working on incorporating this guidance into people's support plans.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and caring in their approach. We observed staff interactions with people and saw staff were friendly and patient towards people when they were supporting them. Throughout our visits we heard conversations between people living at Heathcotes (Moorgreen) and staff and these were warm and respectful. We saw several good examples of staff sitting and talking with people in a very relaxed and informal manner.

People had choices about how they wanted to be supported and spend their time. For example, where people wanted to stay in bed and get up late, this was respected. People were involved in decisions about their support. Staff talked and communicated with people in a way they could understand and they encouraged people to make decisions and choices. During our visits we saw that people were, as far as possible, involved in decision making and staff routinely checked with people about their preferences for support. Staff we spoke with had an understanding of their role in ensuring that people had choice and control. People's support plans contained details of how they communicated and any support they needed, for example one person's plan stated, "To help me understand do drawings." We observed that written information such as menus were produced using signs and symbols to ensure that they were accessible to people who used the service.

People had access to an advocate if they wished to use one. Advocates are trained professionals who support, enable and empower people to speak up. One person who used the service was using an advocate at the time of our visit. The service manager explained that they had made links with the local advocacy service and were waiting for delivery of information leaflets.

Staff had a good understanding of people's needs for support and reassurance. Staff spoke with insight about the anxieties experienced by people who used the service and during our visit staff responded quickly and appropriately to attend to and relieve people's distress and upset and ensure other people's safety.

Observations and discussions with staff showed that staff knew people's needs and preferences. People's support plans recorded their preferences for how they were supported along with their personal history, likes, dislikes and what was important to them. We observed that staff had a good knowledge of what mattered to people and used this to inform conversations. We spoke with a member of staff who told us, "I know there are certain things in [person who used the service] past that are difficult for them so I try to avoid talking about things like that with them." People's bedrooms contained photographs, pictures and other personal items that were important to each person.

People were supported to be as independent as possible. The service manager told us people's independence and the development of their daily living skills were integral to the service. They told us, "We are developing people to move on and live more independently." There was information in people's support plans about how to maximise people's independence. Staff told us people were encouraged and supported to be involved in household tasks including cooking, cleaning and laundry and people were also provided with assistance to manage their own finances. We spoke with the occupational therapist who described how

they were working with one person who had expressed a desire to become more independent in the community, they told us how they were currently exploring ways to enable this to happen in a safe way.

People's rights to privacy and dignity were respected. We observed that people's privacy was promoted throughout our visit. Staff knocked on people's doors before entering and they ensured that people were enabled to have private space when they needed it. Staff told us about the various ways they supported people to maintain their privacy, which included not entering people's bedrooms without their permission. A member of staff we spoke with told us, "Yes we respect people's privacy, it just comes naturally." In addition to this staff respected people's right to confidentiality. Conversations about people's support needs were held in areas that could not be overheard and care records were stored securely.

Requires Improvement

Is the service responsive?

Our findings

People told us that they did not always receive the care and support that they required. One person we spoke with told us there were times when they had been left without their one to one support as staff were busy responding to incidents with the other people who used the service. They told us, "The staffing issues are upsetting me, it is emotionally upsetting." We spoke with the service manager about the impact of staffing levels on people's support who acknowledged that there were times when staff had to be "pulled off" one to one support to deal with incidents. This perceived lack of support could potentially have had a detrimental impact the person's wellbeing.

People were not always provided with consistent care and support. Although each person who used the service had a support plan containing information about support they required these plans sometimes contained contradictory information and staff we spoke with did not always follow guidance contained within the plans. One person who used the service told us, "Some staff are not consistent with their approach (and) lack experience." For example one person was at risk of absconding from the service, there was guidance in the person's support plan which directed staff to phone the person regularly when out alone in the community however different timescales were recorded in different pages of the plan. The plan also stated staff should record contact attempts. Records showed that this person accessed the community independently most days, however records of contact were not kept as detailed in the support plan. We spoke with a member of staff about how frequently they contacted the person when they were out alone and they told us, "We don't phone [person] regularly when they are out as it would wind them up. We ring them a couple of times." This placed the person at risk of inconsistent support and potential harm.

Prior to admission into the service one of the dialectical behaviour therapists assessed people's needs to ensure that the service could meet them. Information relating to their medical history, care and support needs was considered by the therapy team and one of the therapists visited the person to meet them and to obtain further information. From this information the team determined whether or not they would be able to meet the person's individual needs. This information was then used to form the basis of the person's support plan.

We found that on the whole people's support plans contained detailed information about each person's individual needs and preferences. Plans included information about what was important to people and also the person's level of independence and areas where support from staff was required. In addition to this there were care plans in place which detailed how staff should support people whose behaviour could present challenges. The regional manager told us that care plans were reviewed monthly or as needed. Staff we spoke with told us that they found care plans easy to use and they were given time to read them. One member of staff told us, "Everybody (staff) says these plans are really helpful."

When possible people were involved in planning their own care and support. The service manager told us that people were offered the opportunity to get involved in the development of their support plans, they told us, "We agree aspects of the plan with people and people have access to their care plans when they need to." It was clear from the content of the plans that people had some input into their plans; however people

who used the service gave mixed feedback about this. One person told us, "They ask me if I want to (get involved in care plan) but I just let them (staff) do it," whereas another person said "I have been here for three weeks and I have not been involved with the planning of my own care yet."

People were offered the opportunity to plan and take part in social activities and people we spoke with told us that they were able to choose how they spent their time. Most people using the service chose to spend a lot of their time out in the community and we saw records which showed that this was the case. Staff we spoke with talked about their role in encouraging and motivating people to plan goals such as college courses. One person who used the service described to us how another person wished to make a cheesecake one evening. The ingredients were not available so rather than disappoint the person, one of the staff team went out to the local supermarket and obtained the necessary items and helped the person to make it. During our visits we saw people watching TV, listening to music and going out. We saw records of meetings where activities were discussed. Despite the above, one person we spoke with told us, "It's good to be out of hospital but there are not really enough activities here."

People were supported to maintain relationships with people who mattered to them. People's care plans included information about people important to them and we saw records to show that people were in regular contact with people who were important to them.

People could be assured that complaints would be taken seriously and acted upon. People told us that they would feel comfortable and confident in raising an issue or complaint with the management team. We spoke with one person who used the service who told us about an issue they had recently raised. We discussed this with the management team who told us that they were aware of the issue and had taken action to resolve it.

Staff we spoke with knew how to respond to complaints if they arose and knew their responsibility to report concerns to the management team. Staff were confident that the managers would act upon complaints appropriately. There was a procedure on display in the service informing people how they should make a complaint. Records showed that when complaints were made they were recorded, addressed and escalated to senior staff members where required.

Inadequate

Is the service well-led?

Our findings

The service provided at Heathcotes (Moorgreen) was unique and innovative. The service was intended to provide specialist accommodation, support and treatment to people with emotionally unstable personality disorders in a community setting. However the provider did not have adequate expertise in the field to ensure that support was provided in a safe and effective manner. This resulted in negative outcomes for people who used the service and put people at significant risk of harm.

Governance systems in place to ensure the safe running of the service were not effective as these were not based on an adequate understanding of the complex needs of this service user group. As a result of this the issues identified during our visits to Heathcotes (Moorgreen) had not been identified and consequently no action had been taken to safeguard people living at the service. Audits conducted by the provider were not tailored to the specific needs of people using the service which meant that these were not comprehensive and did not identify issues and areas for improvement. The provider had not identified the necessity to complete a risk assessment of the environment specific to the risks posed by the group of people supported at Heathcotes (Moorgreen). As a result people were unnecessarily placed at risk of serious harm.

A record of accidents and incidents occurring at the service was kept and this information was also shared with the regional manager. The regional manager told us they reviewed this information on a monthly basis to identify any trends and take action as needed. Despite this we did not see any evidence which demonstrated that improvements were made to the service following incidents. For example there had been an incident where two members of night staff had left two people unattended in the service for a short period of time in the early hours of the morning which put these people at risk of harm. This was reported as an incident however no action had been taken to investigate the incident until we raised it following our December 2016 visit. Furthermore we were notified of a number of recent incidents where people who used the service had attempted to harm themselves using items available in the service. There were no records to show that this information had been analysed and we saw no evidence that action had been taken to make changes to the environment to reduce the likelihood of future incidents. This meant there was a lack of learning or action from incidents and people were place at risk of avoidable harm.

Management structures in place at Heathcotes (Moorgreen) were not effective. This had resulted in a lack of leadership, coordination and action. For example an inspection had been conducted by the fire service in October 2016 and a deficiency notice had been issued which detailed a number of improvements that were required to ensure the safety of people who used the service in the event of a fire. During our November 2016 visit we found that the management team were not aware of the deficiency notice until we informed them as the notice had been filed without any action having been taken. During our visit the registered manager took swift action to share the notice with the provider's health and safety team to ensure action was taken.

In addition to this, during our December 2016 visit we found that staffing levels were not sufficient and the service was not always staffed at the required level. Whilst the service manager told us that they were aware of this issue, assertive action had not been taken to ensure staffing levels were at the required levels to ensure people's safety.

Responsive action was not always taken by the provider in relation to known issues and this left people exposed to potential harm for unnecessarily prolonged periods of time. For example there were known issues with bedroom doors that were designed to ensure staff could quickly access people that barricaded themselves in their rooms. Two doors had been damaged approximately two weeks prior to our December 2016 visit. During our December 2016 visit the management team told us that they had taken action by reporting this to the provider but the provider had not taken any action to rectify these issues. A member of staff told us, "It takes a long time to get anything done."

Clear and up to date records were not always kept of care and support provided. We found that incident records were not always completed immediately after incidents and we also found multiple gaps in daily records of support provided.

Appropriate policies and procedures were not always in place to safeguard people from harm. For example one person was able to access the community unescorted and was at risk of bringing back items that could be potentially harmful. The service manager told us that there was no policy or procedure in place to search the person or the person's room for these objects to reduce the risk of harm. In addition to this the service had a specialist ligature knife that was used for removing ligatures safely. Ligature points are fixtures to which people intent on self-harm might tie something to strangle themselves. There was no policy or procedure in place relating to the use, maintenance or storage of this piece of equipment and the service manager did not have any knowledge of maintenance procedures such as sharpening to ensure its safe and effective use.

All of the above was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the provider took action to develop an action plan based upon the feedback we shared and informed us that action had been taken to ensure the safety of people who used the service.

There was a registered manager in place who had a background in working with people with personality disorders. However she explained that she was the regional manager in a different geographic location so was not present on a day to basis to oversee the running of the service. The provider had recently recruited a service manager and they were planning to make an application to the CQC to register, however this had not yet been completed. Following our inspection the provider informed us that changes to the management structure were underway.

Although the management team had notified us of some events in the service, they had failed to notify us of a number of incidents when the police had been called to the service. A notification is information about important events which the provider is required to send us by law. We spoke with the registered manager and service manager about this and they assured us that they were now aware of their responsibilities to notify us of these incidents.

People who used the service were supported to have a say in how the service was run. Regular meetings were held for people who used the service. We saw records of these meetings which showed that they were used to discuss activities, food and menus and any issues. The regional manager told us that the provider also conducted an annual customer satisfaction survey. This had not yet been completed at Heathcotes (Moorgreen) as the service had only been operational for a short period but we were informed that it was planned in the near future.

People who used the service were involved in making decisions about the staff that supported them. The

service manager told us that when possible they always tried to make sure that a person who used the service is involved in interviewing new staff. They told us "[Person who uses the service] asks questions at the interview and gives a thumbs up or down which is recorded on the interview form."

Staff were given an opportunity to have a say in the running of service in regular staff meetings. One member of staff told us, "Yes we have team meetings, the team leaders give us information too." Records of staff meetings showed that these were used to discuss how things were going for each person using the service, training and to address issues within the team.

Staff told us they were happy working at Heathcotes (Moorgreen), one member of staff told us, "It's a kind place to work." They were aware of their duty to whistleblow on poor practice and felt confident in raising any concerns with the management team. Staff were positive about the managers. One staff member commented, "I think the managers are all great, if I need something they are approachable."

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risks associated with their environment. People were not protected from the risks associated with their care an support. Medicines were not managed safely. Regulation 12 (1) (2) (a) (b) (d) (h)

The enforcement action we took:

We imposed an urgent condition on the provider's registration to prevent them from admitting any new residents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were not adequate systems or processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who used the service. Records of care and support provided were not accurate, complete or contemporaneous. Swift action was not taken to improve practice in response to known issues. Regulation 17 (1) (2) (a) (b) (c) (f)

The enforcement action we took:

We imposed an urgent condition on the provider's registration to prevent them from admitting any new residents.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	There were not sufficient numbers of staff available to provide safe and effective care and support. Staff did not always receive appropriate training and support to enable them to carry out their duties. Regulation 18 (1) (2) (a)

The enforcement action we took:

We imposed an urgent condition on the provider's registration to prevent them from admitting any new residents.