Heathcotes Care Limited

Heathcotes Enright Lodge

Inspection report

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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

We inspected the service on 11 and 13 December 2018. The inspection was unannounced and was the provider's first inspection since it was registered.

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.

Heathcotes Enright Lodge is a care home and accommodates up to six people with a learning disability and or autism and complex mental health needs. The service consisted of one bungalow for four people and two individual flats in another building. Within the same grounds the provider had a second registered location Heathcotes Enright view that provided the same service for seven people. The management and staff team managed and worked across both services. People received high levels of staff support. On the day of our inspection, two people were living at Heathcotes Enright Lodge.

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." Registering the Right Support CQC policy.

There was no registered manager in post at the present time and an interim manager was managing the service with oversight by senior managers. 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 supported by sufficient numbers of staff, and skill mix and competency was a concern. Staff had not all completed an induction on commencement of their employment, due to how the three day induction was delivered. There was high use of agency staff, who did not all have relevant skills and experience in working with people with complex needs. Concerns were also identified in the induction agency staff received. Significant gaps were also identified in the training staff had received, which the provider required staff to complete. Staff did not consistently receive opportunities to discuss their work, training and development needs.

Risks associated with people's needs were not consistently and effectively managed. Incidents were not sufficiently reviewed and robustly analysed, to consider themes and patterns and how lessons could be learnt and improvements made.

National best practice guidance in the management of medicines was not consistently met. This included how medicines were checked and recorded. Guidance and instruction for staff also lacked detail in places.

Whilst some changes had been made to make improvements, these required further time to be fully embedded.

Staff found it difficult to keep the environment clean due to the time available whilst supporting people. Checks associated with legionella was not fully completed. This was in relation to water flushes in unoccupied bedrooms.

The provider recruited staff after completing checks. This ensured, as far as possible, staff were suitable to work with people. Staff could identify the potential signs of abuse and knew who to report any concerns to. Action had been taken to safeguard people when concerns had been identified.

The provider was not consistently working in accordance with the Mental Capacity Act 2005 (MCA). Consent to care was not always sought in accordance with legislation and guidance.

People's health needs were not consistently met. People had experienced missed health appointments and or, their health needs were not monitored as required and this not been identified by staff. This could have impacted on people's health and well-being. People had limited access to a choice of foods because food stocks were not managed well.

Staff were kind and caring and respected people's privacy and dignity. However, the deployment of staff and skill mix, impacted on people receiving consistently good care and support. People were involved as fully as possible in their care and support. Independence was promoted and advocacy information and support was provided to people.

People's support plans were not easy for staff to follow they were repetitive and lacked guidance in places. People were happy with the activities and opportunities they received and social inclusion was encouraged, people accessed their local community regularly. People had access to the provider's complaint procedure. At the time of our inspection no person was receiving end of life care, and discussions about end of life was not appropriate given people's needs and recent transition to the service. However, documents were in place and ready for staff to discuss people's end of life preferences when deemed appropriate.

The provider's systems and processes to assess, monitor and improve the service was found to not be fully effective. Staff morale was low with staff concerned about staffing levels and competency, high use of agency staff and poor communication systems. External professional and agencies had significant concerns about how the service was meeting people's individual needs. However, people who used the service, relatives and advocate we spoke with were overall positive about the care and support provided.

During this inspection we found four breaches of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 act 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 act 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.

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.

There were insufficient staff deployed to meet people's individual needs and safety, concerns were identified with staff skill mix and competency.

Risks associated with people's individual needs and safety were not consistently met to protect their health, safety and well-being. Incidents were not sufficiently analysed or lessons learnt.

National best practice in medicines management was not consistently followed.

Legionella checks were not fully completed to reduce risks. Staff had limited time to keep the environment clean.

Staff were aware of safeguarding procedures.

Is the service effective?

Inadequate

The service was not effective.

Significant gaps were identified in how and when, staff completed their induction, training and received opportunities to discuss their work and development needs.

The Mental Capacity Act 2005 was not consistently adhered to.

People's health needs were not consistently met.

Food stocks were found to be low.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and caring, but staffing levels and competency impacted on people consistently receiving good care and support.

People received opportunities to be involved in their care and

support as fully as possible.

People had access to advocacy information and support. Independence was promoted and privacy and dignity respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Support plans were not easy for staff to use and lacked detail in places.

People received social and community opportunities. Information available for people considered people's communication and sensory needs.

The provider's complaint procedure was available for people and visitors.

End of life documents were available for staff to complete with people.

Is the service well-led?

Inadequate

The service was not well-led.

The provider's internal systems and processes to assess, monitor and improve quality and safety were not sufficiently robust.

People who used the service were happy with the care and support they received. Relatives were overall positive about the service provided, but concerned about the high use of agency staff. External professionals had concerns about staffing levels, staff training and competency and how the service was managed.

Heathcotes Enright Lodge

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 planned 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 provide a rating for the service under the Care Act 2014.

The inspection was prompted in part due to concerns relating to an increase in safeguarding notifications. We had also received information from local commissioners raising concerns about how risks, quality and safety were managed. At the time of this inspection, both the local authority and local clinical commissioning group had suspended their contract with the provider.

This was a comprehensive inspection that took place on 11 and 13 December 2018 and was unannounced. The inspection team in total consisted of three inspectors and an expert-by-experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On this occasion we did not ask the provider to send their provider information return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, at the inspection we offered the management team the opportunity to share information they felt relevant with us.

During the inspection, we spoke with one people who used the service, but this was limited in part due to their needs and not wanting to spend time with us. We contacted one relative via telephone for their feedback. During the inspection we also spoke with the regional manager, director of operations, the interim manager, deputy manager, two team leaders. We also spoke with three night staff, three day staff and an agency worker. We looked at the care records of two people who used the service. We checked that the care they received matched the information in their records. We also looked at a range of information to consider how the service ensured the quality of the service; these included the management of medicines, staff training records, staff recruitment and support, audits and checks on the safety of the environment, policies and procedures, complaints and meeting records.

Inadequate

Is the service safe?

Our findings

There were insufficient numbers of staff deployed to meet people's individual needs. Staff skill mix and competency was also a concern. a relative and external professionals, raised concerns about the high use of agency staff, staffing levels and training staff had received.

Three staff were on duty at night for both services. Night staff spoken with told us they felt this was not safe in meeting people's needs. In addition, other staff also told us they were concerned the night staffing levels were not safe. Whilst staff had raised this as a concern, they had been told by senior managers, staffing levels matched the funding received.

Three staff were expected to safely manage any behaviours people experienced and monitor their health, safety and well-being. This also included administering people's prescribed medicines when required, to manage high levels of anxiety or for pain relief. The staff also completed cleaning tasks at the service. One person required one staff member always and the remaining two staff monitored the other five people. Some people required staff to manage high levels of behaviours by using physical intervention as a last resort, if all other behavioural strategies failed. When physical intervention had been used, this could take up to three staff. This meant if this type of physical intervention was required, there would be no staff to monitor and support other people.

People's care records and staff handover records, showed how people had been unsettled during the night requiring staff support. This included the support of the police on one occasion due to the level and intensity of anxiety and behaviours being displayed. Following our inspection, we were notified by the provider of another person who had displayed high levels of challenging behaviour towards staff and the environment and staff required police support. This shows that three staff were not sufficient to safely and effectively meet people's needs and safety.

Staff skill mix and competency was a significant concern. Not all staff had received training in physical intervention. In agreement with external healthcare professionals, there had been a change in the accredited physical intervention used at the service. This was due to the type and level of behaviours people could present with. This training was being delivered by external healthcare professionals and ten staff were still to receive the training, including the deputy manager. When we raised this as a concern with the management team, they told us staff had received another type of physical intervention training that was previously used. However, the staff training plan showed six staff had not received either training. We were also concerned that during the transition of the new training being delivered, there was confusion as to how and what physical intervention should and could be used.

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

Medicines were not consistently managed following best practice guidance. The management team told us there had been some recent changes in the system used to administer medicines. Support had been

provided by a community pharmacist. However, they acknowledged further staff training was required to fully embed changes made.

We found inconsistencies in how people's prescribed medicines were managed. For example, the blister pack for one person's lunchtime medicines showed these medicines for the current day had already been removed. Staff told us this was because there had been a problem with one of the medicines earlier on in the week. This meant staff had to dispose of it, and open the next day's medicines to make sure the person received them. We were told the reason for this was one of the medicines had disintegrated when the pack was opened. There were four medicines in each lunchtime pack. There was no record on the medicine administration sheet of what had happened, and there was no record of the other three medicines which were not needed, being disposed of. The team leader had not been on duty and could not tell us accurately which medicine had disintegrated. We looked through other records such as communication books, we spoke with the interim manager, but there was no written information to say what had happened. This meant we could not be assured there was clear oversight and accountability of medicines management.

One person had been prescribed a pain relieving cream for their knees. The prescription said the medicine should be administered up to three times a day. The team leader we spoke with thought this meant they had to be administered three times a day. There was nothing in the record to indicate when the cream might be best administered to meet the person's needs. For example, in the evening after they had been walking around more.

Stock checks were completed to monitor medicines, but the way this was recorded meant it was difficult for staff to clearly know what stocks were in place. One person was administered paracetamol for pain on an 'as required' basis. We saw no medicine plan to inform staff what the person's pain might be, and why they might need this administered to them. Plans were in place for the use of medicines 'as required' to manage high anxiety and behaviours. However, there was no reference to the strategies staff should use before administering these medicines. Medicine plans help staff to provide consistent medicine support to people and ensures medicines are used as a last resort.

Risks associated with people's needs had been assessed and planned for, but some inconsistencies were found in how staff followed guidance. For example, one person had complex behavioural needs that meant access to items in their living environment, could pose a risk to them. Staff were informed to remove items when the person was showing high anxiety. The management team told us this person often did not show any indicators that may predict they were at risk of harm to themselves. Incident records also showed there was not always a known trigger before a behavioural incident occurred. However, incident records showed on 3 November 2018 the person was highly anxious and self-harmed. A further incident occurred the following day where they had access to items and self-harmed again. Another person had been given access by a staff member to their personal social media account and this had raised safety concerns. Another person who had their own access to a social media site, had put themselves at risk. In both instances there were no risk assessment in place to provide staff with guidance of how to manage these risks. This meant risks were not always managed effectively.

Risks associated with people's needs had not always been planned for. For example, one person had medicated cream which contained paraffin. The person was also a smoker. This meant they were at risk of the paraffin being set alight when they smoked. We saw that a team leader had contacted the NHS to discuss this, and the notes indicated that if the person was 'careful' they would be fine. However, this information had not been transferred into a risk assessment for other staff to be aware of.

Positive behavioural support plans provided staff with guidance of potential behaviours and risks. This

included strategies to manage and reduce behaviours from escalating such as using diversional techniques. As a last resort, staff could provide physical intervention if they had received specific accredited training. However, the level of guidance that instructed staff of what assessed physical intervention could be used and duration was not documented. Neither was there any consideration of any health conditions, including self-injury behaviour. This meant there was a risk that people may not have received safe physical intervention that met their individual needs.

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

Risks associated with the environment were also not consistently managed. Water flushing in unused bedrooms were not completed as part of the checks, in reducing risks associated with legionella that can cause serious illness. Personal evacuation plans and a business continuity plan were available but needed to be updated. This is important information for staff of the action required to safely evacuate people and how to manage an event that could impact on the safe running of the service.

Staff did not have ID badges or the use of a mobile phone when supporting people in the community. A staff member told us how they had to manage a difficult situation whilst working alone with a person in the community. The management team told us all staff should have an ID badge as per the provider's policy and was unable to provide an explanation as to why staff did not have one. The regional manager told us plans were in place to issue staff with an ID badge and work mobile phones. Within the service staff had the use of walkie talkies to communicate with each other and call for assistance.

Action had been taken to safeguard people from abuse from others living at the service. For example, a person had been moved from a communal bungalow to a single occupancy flat with their agreement. This was within the same site and was due to safeguarding concerns they posed to others. In addition, staffing levels had increased to support this person from risks to themselves and others.

Staff were aware of their responsibility to protect people from abuse and avoidable harm. Feedback from relatives and an advocate included, 'I'm reasonably satisfied for [name of person]'s safety. It's difficult to tell but they would previously say if they were unhappy." "[name of person] feels safe and they are clearly at ease."

A staff member said, "We report any concerns to the team leader, manager or deputy. I know they report on to the safeguarding team." The provider had a safeguarding policy and procedure that supported staff. The management team had worked with the safeguarding team and commissioners when safeguarding incidents had occurred to reduce further risks.

People were protected from the risk of infections and cross contamination. Staff were aware of the prevention and control measures to reduce risks. This included good hand hygiene and the use of protective equipment such as aprons and gloves. On the day of the inspection, people's living environment was found to be clean. Whilst cleaning schedules were completed by staff, they told us cleaning could be difficult to complete because the primary role was to support people. They understood it was the provider's expectation to involve people in domestic tasks as fully as possible to encourage independence but said this was difficult at times.

The environment was secure. There was a locked gate to the property which could only be opened by team leaders, who had the keys, coming out of the buildings and opening it. We recognise this was positive in making sure that those who had their liberty legally deprived, were not able to leave the building. However,

it was also a challenge for staff to have to stop what they were doing, to open the gates to let other staff or visitors into or out of the property.

Inadequate

Is the service effective?

Our findings

The staff induction, training and support was significantly ineffective in supporting staff to fully understand people's needs. External professionals raised concerns about the lack of staff training and the impact this had on people's needs being fully understood and managed effectively.

Concerns with staff induction was identified. The staff training plan showed 12 staff who commenced their employment within the last three months, had not completed an induction. Three of these staff had completed some training but not the full induction. This included both the interim manager and deputy manager. The management team told us the induction was provided in three-day blocks and this was next planned to be delivered in January 2019. This meant six support workers had received no training, this impacted on their ability to provide effective care and support to people who had very complex needs. One staff member's training file showed they commenced their employment on 18 October 2018 and their induction and care certificate was signed as all completed on 22 October 2018. This is a set of standards that sets out the knowledge, skills and behaviours expected from staff within a care environment. This raised concerns of how effective the induction had been.

There was significant use of agency staff. The agency staff records showed information relating to 26 agency staff. Twenty of these staff did not have an induction record completed, one record had no photo ID to confirm who the staff was. Whilst some staff had relevant training in learning disability, mental health and accredited training in physical intervention not all had this level of training. Whilst an agency worker had told us they had received an induction, we were not assured all agency staff had. This meant people were at risk of receiving ineffective support.

The staff training plan also showed gaps in training the provider had identified staff were required to complete. For example, out of 28 support workers, 20 had not completed training in personality disorder, 22 had not received training in mental health awareness and ligature removal. Night staff had not fully completed training in the administration of medicines. This meant if a person required a prescribed medicine to be taken 'as required' as a last resort to manage high anxiety and behaviours, night staff had to call for assistance from the on-call manager. This was a concern because a delay in people receiving this medicine may add to escalating behaviours.

Team leaders told us how they considered how staff were deployed, such as training completed, and staff's confidence and competency, but this was difficult and caused them great anxiety. People's pre-assessments advised they required experienced staff. There had been a high turnover of staff since the service opened and ongoing difficulties in recruitment and retention of staff. Not all staff had any previous experience of working in a care setting and staff who had care setting experience did not always have experience of working with people with complex mental health needs. Opportunities for staff to meet with their line manager to review their work, training and development needs was limited. The management team told us they were aware the frequency of staff supervisions needed to be improved upon.

This was further evidence of a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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.

We found there were inconsistencies in how the MCA was being adhered to. For example, a person had restrictions on when they had a cigarette and the frequency of some drinks. Whilst this was deemed to be in the person's best interest in relation to their health needs, there were no mental capacity assessments and best interest documentation. This is required to show how and who, had been involved in these decisions. We saw this person frequently asked for drinks and cigarettes and whilst they showed some awareness of why these restrictions were in place, their behaviour indicated they lacked mental capacity to consent to this. Whilst a person had been assessed as having mental capacity for all decisions, no consideration had been given to fluctuating capacity at times of when they were mentally unwell or their decision making was impacted when intoxicated. This meant people's mental capacity had not been correctly assessed and procedures followed.

One person had a standard authorisation that restricted them in relation to their freedom and liberty. As part of their authorisation, there was an attached condition. The provider was requested to complete mental capacity assessments and best interest decisions in how care and support was provided. We did not see that these had been completed. This meant the provider had not met requirements expected of them.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's healthcare needs were not consistently met. For example, one person was required to have their blood levels taken regularly, due to a prescribed medicine. This was important because this medicine is subject to strict monitoring, and blood tests are required as part of the safety measures in place. This person missed an appointment to have their blood levels taken. A second person required a mental health review but missed the appointment. A third person had needs associated with bowel management which needed to be monitored. A visiting healthcare professional identified this monitoring had not taken place, and healthcare professionals alerted the management team about the missed health appointments. This demonstrated a lack of communication and organisation within the staff team and put people at unnecessary risk.

People did not consistently have access to sufficient food stocks. The staff team told us this was an ongoing concern. The management team told us how staff were required to menu plan with people and go food shopping on a Monday and complete a second shop during the week with people. Staff told us whilst people were expected to go food shopping with them as part of their activities, they regularly chose not to do this. We found food stocks were low and on the first day of our inspection, one person did not have any spread to make a sandwich. This meant there was a risk people may not have sufficient food available and choices were limited.

The service was not registered with the food standard agency, an email application was submitted on 4 December 2018, eight months after the locations was registered. This showed that the provider had not met the requirements of registering with the food agency.

The provider had policies and procedures that reflected best practice guidance and current legislation. This included an awareness and understanding of social inclusion for people with complex needs. However, we found some inconsistencies in the information recorded about important key information. For example, not all people had recorded their sexuality or religion. This is important information to ensure they do not experience discrimination and staff know what support is required.

Staff worked with external professionals and shared any relevant information to support others in the care and support of individuals. People were accompanied by staff to any appointments including hospital visits due to their complex needs.

Requires Improvement

Is the service caring?

Our findings

Whilst staff were kind and caring the provider had not ensured staffing levels were correct for people to receive consistent care. The high use of agency staff, meant the quality of care was compromised at times because people were not supported by staff that knew them well. People had very complex needs and required a stable staff team that knew them well to provide consistent and continuity in care.

People spoke positively about the staff that supported them. A person said, "The staff are lovely." And, "I am happy, I like it here, I am not leaving!"

The staff we spoke with, showed an understanding and awareness of people they were supporting. This included what was important to people and their routines. Whilst they told us improvements were required at the service they were also positive about their work. A staff member said, "We support people with activities, to try different things important to them, [name of person] I've taken to a football match, I supported them go to college. It's a balance of giving people opportunities and meeting their needs." Another staff member said, "[Name of person] has come on so well since being here, it's amazing. They are more confident and outgoing."

Our observations of staff engagement were limited due to people's anxieties about having unfamiliar people in their environment. However, we did see some good examples of staff interaction with people. For example, staff were responsive to requests from people to go out. Staff used good communication and had a positive approach with people. When people's anxiety levels increased, staff had a calm and reassuring approach and used diversional techniques well to deescalate any potential behaviours. For example, one person wanted to go to the shop to purchase their cigarettes. Staff knew this was the person's morning routine and was important to them and arrangements were made to support the person without delay. One person required two staff with them and we spoke with one staff member who told us they had a good relationship with the person. We were aware this staff member was working with the same person for 14 hours each week and asked them about this. They said, "[Name of person] is better with more mature female staff and if it keeps them calm and relaxed I really don't mind."

Independent advocacy information had been made available for people. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. A person was supported by an independent advocate.

People were involved as fully as possible in discussions and decisions about their care. A person said, "The staff ask me things and listen to me." Feedback from relatives and advocate was positive about being involved and consulted. Comments included, "I joined in the last review over the phone on a conference call, I was able to get my views, or concerns across."

An example of a person being supported in their care, was how they had developed a contract with staff about how they wanted to receive their support. We also saw records of meetings between staff and people, where discussions included what was working well and what could be improved upon, such as activities.

People we spoke with told us they wanted to eventually live in the community with less support, and wanted to develop their independence. People's support plans included promoting independence at every opportunity and staff were clear their role was to facilitate this. This meant people being included in daily domestic tasks, for example money management such as paying for items when shopping.

People's privacy and dignity was respected and understood by staff. People had high support needs and required close monitoring, this was either by one staff member or two. A staff member said, "People have one to one care, but we give them space and when bathing and showering we make sure they haver privacy." And, "If people want to sit by themselves, we would just sit in the next room."

We saw staff were polite and respectful when interacting with people, choices were offered and acted upon. This included choice with meals, drinks and how people spent their time. We spoke with a person who was going shopping with staff, they wanted to purchase some new shoes and told us where they were going.

Requires Improvement

Is the service responsive?

Our findings

Although people had a pre-assessment of their needs and a transition plan was completed prior to moving to the service. A transition plan provides support and prepares people to familiarise themselves with their new environment and support before they moved to the service. We received some concerns from staff about the transition. A staff member said, "There has not always been a proper transition period which meant there was no time to get to know the person before they moved to the service."

Following the assessment of people's needs support plans were developed with people and significant others, such as relatives and health and social care professionals. Staff told us they found guidance and information in support plans difficult to follow and repetitive. A staff member said, "Paperwork is disorganised." Another staff member said about support plans, "I think they could be better organised to make it easier to take in."

From reviewing people's support plans and other records, we also found information was not always easy to follow. For example, one person had two health conditions, but their support plans provided limited information. One condition meant their balance could be affected, but staff were not provided with any information or guidance as how this may affect the person. Another health condition did have information on how the condition could present, but it was unknown if the person had experienced these symptoms. Neither of this information was easily found in the person's care records and could have easily have been overlooked. Staff spoken with showed some awareness, but this was limited. This meant people may not have received responsive care and support that met their individual needs.

Where people had known health conditions staff were not provided with consistent guidance. For example, two people had asthma. One person had no support plan or risk assessment in relation to the support required. The second person had a generic support plan that gave limited guidance of how the asthma affected them. Staff awareness of these people's needs was variable, meaning people could not be assured they would receive correct support.

One person's pre-assessment stated they had high blood pressure that required monitoring. This information was not recorded in their health action file. The management team told us staff would not be expected to monitor blood pressure and this would be completed by a healthcare professional. Due to no recording in the person's care records and a lack of awareness of staff, we could not be assured the person was being supported with this health need.

Another person's pre-assessment stated they needed support to eat healthily. However, there was no nutritional support plan to guide staff of the support required. Fluid charts were in place that recorded daily fluid intake due to the person having an infection. However, there was no daily target advising staff what the person should be drinking, and the charts were not routinely completed. It was unclear how and who was monitoring this and if this was still required.

People's communication and sensory needs were known and understood by staff. Support plans provided

staff with guidance. For example, a person was reluctant to wearing hearing aids and this was recorded. Staff were informed of the importance to gain the person's attention before communicating and to use visual resources. Key documents were provided in an easy read format to support people's communication, such as activity plans, the service user guide and the complaints procedure. This meant the provider was meeting the Accessible Information Standard. This standard expects providers to have assessed and met people's communication needs, relating to a person's disability, impairment or sensory loss.

People told us they received opportunities to pursue activities and access the community. A person said, "I do everything, going to see Mum next week." They also told us they had been to the cinema and local library and enjoyed looking after their pet rabbit. This person had started to personalise their flat and had plans to purchase more items and the regional manager said they would be supported to go shopping. Another person told us they were happy with their flat and had everything they wished, we saw their flat was also personalised to their needs and preferences.

Staff told us people had individual activity plans that had been developed with them and were based on their interests and hobbies. A staff member said, "People have their own plans and are aware of these, but activities can be flexible." A person told us they were happy with the activities available. On the first day of our inspection, they were supported to have a meal out and we noted this matched the days planned activity. Staff told us how one person had been attending college until recently, to develop their numeracy skills, but at present had decided they did not want to pursue this. During our inspection we saw staff were allocated to support named people with activities of their choice.

People had access to the provider's complaints procedure and people told us they would speak with staff if they had any concerns. At the time of our inspection, there had been no complaints received.

At the time of our inspection no person was receiving end of life care. However, people had an end of life document to record their wishes and what would be important to them at the end stage of their life. These plans were still to be completed with people and was a sensitive topic to discuss at such an early stage of their placement.

Inadequate

Is the service well-led?

Our findings

Significant concerns were identified with the provider's systems and processes in place to effectively assess, monitor and improve the quality and safety of the service. Following audits completed by Nottinghamshire County Council and the local clinical commission group in October 2018, the provider had developed an action plan to make the required improvements. However, we were concerned that the provider's internal quality assurance, audits and checks had not fully identified concerns that external agencies had. This included shortfalls in the fundamental care standards we identified during our two day inspection. This included poor oversight and action to ensure staff were sufficiently trained, competent and supported. Staff deployment had not been adequately assessed and monitored to ensure people's safety. Health and safety checks were not sufficiently robust. This meant people were exposed to unsafe care and support.

The provider's internal quality team audit dated 11 October 2018, showed a compliance rate of 60% and another audit dated 15 November 2018 79%. Nottinghamshire County Council audit completed on 17 and 23 October 2018 gave a score of 15.79%. This demonstrated the quality of the provider's systems and processes were ineffective in identifying areas that required improvement.

During our inspection, we found concerns in how lessons had been learnt to drive forward improvements. For example, prior to our inspection visit we had been made aware through safeguarding procedures, that a person had missed an appointment for their blood test. During our inspection, we looked to see whether any lessons had been learnt because of this. We were told that the appointment for the blood tests was now kept in a diary. However, there was nothing contained within the person's medicine record to inform of the blood tests, the results, any changes to the medication, and future test appointments. This would have been a more effective way of reminding staff, as they would see the date every time they supported the person to have their medicine. During our inspection we were also made aware that a second person had missed a health appointment. This further demonstrated lessons learnt regarding communication systems and processes were ineffective.

A repeated concern raised by staff was about a lack of communication and the level of information shared during staff shift handover meetings. We reviewed a sample of handover records and observed two staff handover meetings. We found these meetings were rushed, some staff arrived late and the quality and quantity of information shared was limited. On both inspection days short notice staff absenteeism was reported and team leaders were expected to get the shift covered. We noted neither the interim or deputy manager participated in staff handover meetings or supported the team leaders in managing the shift and delegating tasks. This lack of management support and oversight was a significant concern.

Incident records showed the management team did not effectively review incidents. Whilst there was some analysis of incidents, this was not sufficiently detailed or the procedure robust to inform the provider of any themes and patterns that required a further review. The incident forms reviewed varied in the level of detail and de-brief meetings were not consistently being completed. This is important for the management team to review with staff, if there were any lessons that could be learnt to reduce further risks. We discussed this with the management team who agreed further analysis was required. Staff reported that some staff were

not confident in completing incident records and incident forms were not accurately completed in a timely manner. On the second day of our inspection the regional manager found three incident reports dated 24 November 2018, 7 and 9 December 2018 that had not been reviewed by the management team. This meant it was unclear if the level of incidents recorded were a true reflection of what was happening in the service.

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

During our inspection, the management team told us of their concerns of recruiting and retaining staff and the action they had, and were taking to improve this. This included a review of the recruitment advertisement, hourly rate of pay and qualifications and experience being more of a focus. The provider was also due to use a different agency that would provide temporary to permanent staff.

At the time of our inspection, the registered manager was no longer employed at the service. The regional manager had day to day responsibility until the interim manager was appointed five weeks ago. However, the regional manager continued to have over sight and visited the service each week. Following our inspection, the provider told us the regional manager would be based at the service permanently and additional management support was being provided to support the management team, with oversight by the director of operations to make the required improvements.

Staff morale was low with staff concerned about staffing levels and competency, high use of agency staff and poor communication systems. However, through discussion with staff, they showed a commitment and positive approach of wanting to make improvements to the quality of the service provided to people.

Due to the Heathcotes Enright View and Heathcoted Enright Lodge being on the same site and managed as one service, there had been some concerns in how statutory notifications had being submitted to CQC. A notification is information about important events, which the provider is required to send us by law, such as serious injuries and allegations of abuse. This helps us monitor the service. However, the management team gave us assurances that improvements would be made immediately to ensure the two services were managed separately in line with registration requirements.

A whistleblowing policy was in place. Whistle-blowers are employees, who become aware of inappropriate activities taking place in a business either through witnessing the behaviour or being told about it. Staff told us they would not hesitate to use the whistle-blowers policy if they had any concerns.

Due to the service being open for seven months, the provider had not yet invited people, relatives and others to give their feedback about the service. However, people who used the service did receive different opportunities to share their views, this was by one to one meetings with staff.

Feedback from relatives and advocate included, "It's now more like an ordinary life for [name of person]." "[Name of person] care has not been good over the years. This is much better." External professionals spoken with during our inspection, told us they had concerns about staffing levels, the use of agency staff and staff training and competency.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not met the requirements of the Mental Capacity Act 2005. 11 (1)

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 Risks associated with people's needs had not always been sufficiently assessed and managed. Medicines were not always managed properly and safely. 12 (1)

The enforcement action we took:

NOD

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality and safety of the service were not effective. Systems place to record and investigate incidents which posed a risk to the health and wellbeing of people who used the service were ineffective. 17 (1)

The enforcement action we took:

NOD

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs. 18 (1)

The enforcement action we took:

NOD