Heathcotes Care Limited

Heathcotes (Moorgreen)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We conducted an unannounced inspection at Heathcotes (Moorgreen) on 12 March 2018. Heathcotes (Moorgreen) is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Heathcotes (Moorgreen) provides short term treatment, support and accommodation for up to eight people who have a diagnosis of personality disorder. On the day of our inspection, five people were using the service.

Heathcotes (Moorgreen) was rated as requires improvement at our last inspection which was in March 2017. During this inspection we found we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach was in relation to safe care and treatment. You can see what action we told the provider to take at the back of the full version of the report

There was a registered manager in post at the time of our inspection visit, however following our inspection visit we were notified that the registered manager was absent from the service. The provider had put temporary management cover in place in the absence of the registered manager. 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.

During this inspection we found the service was not consistently safe. Staff did not always have an adequate understanding of people's health conditions and this had resulted in incorrect medicines being administered when their health needs deteriorated. In addition, staff did not always have clear information to guide the administration of these medicines which meant there was a risk people may not receive these when required. Guidance for staff about physical interventions was not always clear which meant there was a risk of inappropriate and potentially unsafe, techniques being used. Systems to review and learn from accidents and incidents were not consistently effective which meant opportunities to reduce the risk of reoccurrence and improve practice may have been missed. People told us they felt safe and there were measures in place to minimise the risk of people experiencing abuse.

Staff were not always effectively deployed, this had been identified and action was underway to address this. There was a risk people may be supported by unsuitable staff as safe recruitment practices were not always followed. The home was clean and hygienic.

Care and support was not always properly planned and co-ordinated when people moved between different services and this had a negative impact on their wellbeing. People were supported to have maximum choice and control of their lives and overall staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People's day to day health needs were met. However, there was a risk that people may not receive the support they needed with specific health conditions as care plans lacked details and staff knowledge was variable. People had enough to eat and drink. Further improvements were needed to ensure people were protected from risks associated with eating. People had access to specialist therapeutic support to aid their recovery, people were very positive about the impact of this support. People were supported by staff who had the skills, knowledge and training to provide safe and effective support. However, some further work was required to ensure staff had a sufficient knowledge of people's mental health support needs and therapeutic aspects of the service. Staff felt supported, however, we found records of staff 'debriefs' after potentially stressful incidents were minimal.

Staff were kind, caring and treated people with respect. People said most staff knew them well and understood their needs and preferences. Some concerns were raised about staff maintaining professional boundaries with people who used the service, the provider told us they had identified this and were in the process of addressing it. People were involved in choices and decisions about their support and were supported to be as independent as possible. People had access to advocacy if they required to help them express their views. People's rights to privacy and dignity were promoted and respected.

On the whole, staff had a good knowledge people's support needs. However, some improvements were required to support plans to ensure people received consistent support. People's diverse needs were recognised and accommodated. Feedback about activities was mixed, some people told us they did not have enough to do and commented that activities could be affected by staffing levels. However, we saw, and records showed people were provided with a range of activities at home and in the community. People were supported to maintain relationships with people who were important to them. There were systems in place to respond to concerns and complaints.

There were systems and processes in place to monitor and improve the quality of the service. However, these were not always fully effective in ensuring areas of concern were addressed. Opportunities to learn from incidents were missed. People and staff were positive about the service and had an opportunity to provide feedback and suggestions for improvement about the service. The registered manager was absent from the service and some people commented on the negative impact of recent staffing changes. The provider had temporary management cover in place and was planning to meet with people who used the service and staff to share further information. The management team responded to concerns raised in our inspection and provided additional information as required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not always receive their medicines as required.

Staff did not always follow guidance in people's support plans to ensure their safety. Opportunities to learn from incidents had been missed.

Staff were not effectively deployed at all times, action was underway to address this. Safe recruitment practices were not always followed.

There were policies and processes in place to minimise the risk of abuse. However, referrals had not always been made to the local safeguarding adults team as required.

The service was clean and hygienic.

Is the service effective?

Requires Improvement

The service was not always effective.

Care and support was not always properly planned and coordinated when people moved between different services.

People were supported to have maximum choice and control of their lives and overall staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People had enough to eat and drink. Where people had risks associated with eating and drinking further information was required in support plans to ensure their safety.

Overall people were supported by staff who had the skills, knowledge and training to provide safe and effective support.

People's day to day health needs were met. However, there was a risk that people may not receive the support they needed with specific health conditions. People had access to specialist therapeutic support to aid their recovery.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with respect.

People were involved in choices and decisions about their support and were supported to be as independent as possible. People had access to advocacy if they required to help them express their views.

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

Is the service responsive?

Good

The service was responsive.

Staff had a good knowledge of people's support needs, some improvements were required to support plans to ensure people received consistent support.

People's diverse needs were recognised and accommodated.

Feedback about activities was mixed. Some people told us they did not have enough to do and activities could be affected by staffing levels. Action was underway to address staffing issues.

People were supported to maintain relationships with people who were important to them. There were systems in place to respond to concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The system to review, analyse and learn from incidents was not effective.

There were systems and processes in place to monitor and improve the quality of the service. However, these were not always fully effective in ensuring areas of concern were addressed.

People and staff had an opportunity to provide feedback and suggestions for improvement about the service.

The registered manager was absent from the service and some

people commented on the impact of recent staffing changes. The provider had temporary management cover in place and was planning to meet with people who used the service and staff to share further information.

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 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.

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events that the provider is required to send us by law, such as, allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

The inspection was undertaken by two 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. During our inspection visit we spoke with four people who lived at the home and two people's relatives on the telephone. We also spoke with four members of care staff, the acting manager, the quality and compliance manager, the clinical psychologist and the area manager.

To help us assess how people's care needs were being met we reviewed all, or part of, three people's care records and other information, for example their risk assessments. We also looked at the medicines records of four people, four staff recruitment files, training records and a range of records relating to the running of the service. We carried out general observations of care and support and looked at the interactions between staff and people who used the service.

We asked the area manager to send us copies of an investigation report and various policies and procedures, which they did prior to this report being completed.

Requires Improvement

Is the service safe?

Our findings

During our March 2017 inspection we found people were not protected from risks associated with their care and support. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found continued concerns about risks associated with people's care and support.

There was a risk people may not receive their medicines as required. Staff did not always have a sufficient understanding of people's health conditions and this posed a risk medicines may not be administered correctly when their health needs deteriorated. One person had a condition which caused them to have seizures. They were prescribed two different medicines to be given in the event of different types of seizures. Staff we spoke with did not have a good understanding of the different types of seizures. Records showed the person had recently experienced a seizure, however, the type and duration of the seizure was not clearly recorded which meant we could not be assured the correct type of medicine had been administered.

There were not always protocols in place to guide the use of 'as needed' medicines. This meant staff did not always have clear information to guide the administration of these medicines. We saw some of the records kept in relation to the use of these medicines did not clearly demonstrate the rationale for their use. For example, one record documented a person became anxious while doing a domestic task and was consequently given 'as needed' medicine to reduce their anxiety. The record did not demonstrate that any of the strategies in the person's support plan had been tried before the administration of medicine. This meant we were not assured 'as needed' medicines would be given appropriately.

Guidance for staff about physical interventions was not always clear which meant there was a risk of inappropriate and potentially unsafe, techniques being used. One person's support plan stated that if they tried to injure themselves in a particular way staff 'should not attempt to stop' them, other than by talking to them. Despite this, an incident record showed staff had recently used a physical intervention to prevent the person from trying to injure themselves in this way. Although we saw this intervention was a success in keeping the person safe, the use of physical intervention was not specified in the person's support plan for this particular situation. Furthermore, the person's support plan had not been updated following this incident to assess whether physical intervention may be required in the future for that particular situation. The same incident record showed the person had also been subject to a significant physical intervention which was not specified in their support plan. This meant staff did not have access to any information about how many staff were required to ensure the safety of the person and others. This failure to provide staff with details of how to use physical interventions safely placed people and staff at risk of harm.

Systems to review and learn from accidents and incidents were not consistently effective. Records of incidents were not always reviewed and this meant opportunities to reduce the risk of reoccurrence and improve practice may have been missed. In one incident record related to the use of physical intervention staff had identified shortfalls in staffing. However, the registered manager had not reviewed the incident record, so no action was taken to address this until staff later raised concerns to the provider. Another incident record documented the person told staff they had become upset as they thought a member of staff

was laughing at them. This had not been identified in the registered manager's review of the incident form and no action had been taken to try to reduce the risk of this happening again. A third incident record documented an incident where a person had become distressed after talking with their relative, this had resulted in behaviour which required staff to perform physical intervention. The section marked 'what can we do different or better next time' was marked 'nothing'. This failure to effectively analyse and learn from incidents meant opportunities to reduce the likelihood of further adverse occurrences may have been missed.

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

Safe recruitment practices were not always followed. The necessary steps to ensure people were protected from unsuitable staff were not always taken in a timely manner. One member of staff had previous convictions on their criminal record. Although there was a risk assessment to assess the potential risk to people this had not been fully completed and was not put in place in a timely manner. This put people at risk of being supported by unsuitable staff. Other staff recruitment files viewed had the appropriate checks in place.

We received mixed feedback about staffing levels at Moorgreen. People who used the service told us they felt there were normally enough staff but commented that changes in the staff team could be unsettling. One person said, "As it's so short staffed, a member of staff will be called in to cover from another of Heathcote's services. This has happened a lot but they all come and do one shift then disappear. I can't build up trust with staff when it's like this." Another person said, "We are always short staffed at the moment." A relative shared concerns about staffing and said it had a negative impact on their relation's wellbeing. Staff told us that there were usually enough staff to ensure that people received their one to one support; however, also said there had been recent occasions when staffing levels were not sufficient. We reviewed staffing rotas, incident records and other reports and found there had been some recent occasions where staff had not been deployed effectively . There had also been occasions where staff deployed did not have the skills required to fully meet people's needs, this had not had an impact upon people as skilled staff from neighbouring services had been utilised. We spoke with the area manager about this, they were aware of some recent issues, had conducted an investigation and were in the process of taking action to address the concerns.

Staff worked long hours and this posed a risk to the health and safety of people living at Moorgreen. One member of staff told us they had worked eight, 14 hour shifts in a nine day period. Although they told us this was their choice, this was not safe as it posed a risk of staff experiencing exhaustion and this increased the risk of error. The area manager told us they were aware some staff were working an increased number of shifts. They said this was due to recent changes to the staff team and recruitment was underway to address this.

During our inspection we received a concern about night staff sleeping on shift. We discussed this with the area manager who was already aware of this concern and told us they were in the process of investigating this.

Other than the above issues identified in relation to medicines, we found medicines were managed safely. People told us they got their medicines when they needed them. The majority of records were completed accurately to demonstrate people had been given their medicines when needed. People's ability to manage their own medicines had been assessed and where people were able they were supported to manage their medicines themselves in a way that promoted their independence and ensured their safety. One person told

us, "I have a safe fitted to the wall in my room and only myself and selected staff have the code for it. I had started looking after my medication before I moved here, so I wanted to continue. I'm doing a days' worth at a time and building towards a week."

People living at Moorgreen told us they felt safe. One person told us, "I feel much safer here as I have developed coping skills through the [therapy]." Another person said, "I'm safe because staff help me when I'm not well, if I feel like harming myself I ask the staff to take things out of my bedroom." There were policies and processes in place to minimise the risk of abuse and staff had received training in protecting people from abuse. However, referrals had not always been made to the local safeguarding adults team as required. Records showed one person had intentionally harmed themselves leading to a deterioration of their health condition and this resulted in a hospital admission. No referral had been made to the local authority safeguarding team to notify them of this serious incident. This meant we were not assured that action would be taken to refer serious incidents to the safeguarding adult's team to enable further investigation if required. After our inspection, the area manager provided evidence that this had now been referred to the local authority safeguarding adult's team. In other areas, we found that appropriate action had been taken to make referrals to the local authority safeguarding team as required.

Information about staying safe was shared with people who used the service. We saw records of meetings which showed issues, such as keeping safe in the home and community, were discussed with the people who lived at Heathcotes (Moorgreen).

The home was clean and hygienic and effective infection control and prevention measures were in place. During our inspection, we observed communal areas were cleaned to a sufficient standard. Most people living at the home took responsibility for cleaning their own bedroom with the support of staff. Records showed the majority of staff had up to date training in the prevention and control of infection and food hygiene. Some areas of the home required maintenance to ensure effective infection control and this work was underway at the time of our inspection.

Requires Improvement

Is the service effective?

Our findings

People told us they felt staff knew what they were doing. Records showed that overall staff had received the relevant training to equip them with the knowledge and skills they needed to support people who used the service. This included, safeguarding adults, the safe use of physical intervention and medicines management. New staff were provided with an induction period when starting work at the service, this included training and shadowing more experienced staff. The induction covered the main components of the Care Certificate. The Care Certificate is a nationally recognised set of standards for staff working in health and social care to equip them with the knowledge and skills to provide safe, compassionate care and support.

Staff told us they felt supported and records showed they had regular supervisions to discuss any concerns and identify any training and development needs. Staff told said they received adequate support or debrief following potentially distressing incidents. The need for debrief was routinely considered as part of the incident process; however, the records relating to debriefs were very basic and in the majority of cases stated there was no need for a de-brief, even after serious incidents.

We recommend the provider ensures that staff have appropriate support by reviewing its practice and recording of staff debriefs to ensure staff are given time to reflect and discuss the emotional impact of serious incidents.

People were supported to eat and drink enough. Although no one we spoke with was able to recall involvement in developing the menu, the area manager told us people who used the service were involved in developing menus and planning meals and provided evidence of this. People were involved in preparing and cooking meals. Three of the four people we spoke with told us they enjoyed helping with the cooking. One person commented, "I like how we can help prepare the food, we all chip in together to cook for everyone." Mealtimes were flexible to suit people's routines and preferences. We observed that people had access to the kitchen and helped themselves to snacks and drinks.

Improvements were required in some areas to ensure staff had adequately detailed information about people's dietary requirements. For example, one person had a food allergy, their support plan only contained basic information about this and staff we spoke with were unsure about the severity of the allergy. We spoke about this with the area manager and quality and compliance manager, they said they would contact the person's GP to get more information.

People were supported with their day to day healthcare needs and were given support to attend regular appointments. People told us if they needed to see health professionals this was arranged for them. One person said, "I had really bad toothache and the staff were ringing round for ages until they found me an emergency dentist." Staff made referrals to physical and mental health specialist teams when advice and support was needed and we saw the advice received was included in people's support plans. Staff sought advice from external professionals when people's health and support needs changed. For example, on the day of our inspection one person was unwell and had struggled to get an appointment with their GP. Staff

provided pain relief and supported the person to ensure they got an appointment to see their doctor.

People had their health needs detailed in both their support plan and health action plan. However, these did not consistently contain adequate detail in order for staff to provide effective support. For example, one person had a condition which caused them to have seizures, although their support plan contained information about this it, was not sufficiently detailed. In addition to this we also found staff were not always aware of the signs of people's health needs deteriorating, such as, indicators or types of seizure. These inconsistencies placed people at risk of not receiving the required support.

People had regular access to support and therapy from a clinical psychologist and occupational therapist (OT) who were employed by the provider. The psychologist and OT specialised in Dialectical Behaviour Therapy (DBT) and ran individual and group therapy sessions for people who used the service. DBT is a therapeutic approach, which helps people to manage their emotions and develop coping strategies to aid their recovery. People we spoke with were overwhelmingly positive about the impact of the therapy provided. One person told us, "I like it here because of DBT, I found it boring at first but I think it's really helped me look at my emotions." Since our last inspection, two people had successfully 'graduated' from their therapy and moved on to more independent living. We saw a testimonial from one person which stated, 'This is a huge achievement for me and I did it by setting myself some goals and taking baby steps to get there using DBT therapy.' This person had also provided support to other people living at the home towards the end of their therapy. People who had moved on from the service continued to access support from the therapy team and this had a positive impact on their transition to their new homes.

Staff had a variable knowledge of personality disorder and DBT. The specialist DBT therapists employed by the provider provided training to staff; however, this had not been effective in ensuring the competency of all staff. While some staff we spoke with had a good understanding in this area other staff had a basic knowledge of personality disorder and reported a lack of understanding of the principles of DBT or their role in the application of the approach. One member of staff had a good understanding and told us, "(Personality disorder) may come across as attention seeking, but it is not, it is their way of dealing with things." In contrast another member of staff said, "It's things like mood swings." This meant some staff had limited awareness of the mental health condition experienced by people who used the service and were not aware of how to apply therapeutic principles to their work to support people's treatment and recovery. We discussed staff competency with the clinical psychologist who felt the majority of staff had a good knowledge but the variations were down to the continuous recruitment of new staff. They felt this would stabilise as the occupancy of the home grew.

Care and support was not always properly planned and coordinated when people moved between different services. During the course of our inspection, we received negative feedback from a service commissioner about the support a person received to move on when the provider deemed they were unable to meet the person's needs. They informed us communication was poor and they were not fully informed about, or involved in, decisions. This had a negative impact on the person resulting in a significant deterioration in their mental health needs. This had been referred to the local authority safeguarding adult's team and had not yet been investigated at the time of writing this report.

In contrast with the above, we found that where transitions between services were planned, there were systems in place to ensure continuity of care. Before people moved into Moorgreen the therapy team conducted an assessment to ensure the staff team could meet their needs. Once a placement had been agreed, plans were put in place to gradually introduce people to the service, with visits and overnight stays. One person told us their recent move into Moorgreen had gone well. They said, "I did one night one week, then two nights the next and gradually built up." We also received positive feedback about planned

discharges. A different commissioner told us, "The therapist and the (registered) manager did a lot of work with [person] in terms of talking through any anxieties about discharge. This was very important to ensure a smooth transition back to the community. In addition they facilitated a lot of transition visits over a significant period of time back to their place of ordinary residence and supported [person] to physically move into new property."

The Mental Capacity Act (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. We checked whether the service was working within the principles of the MCA.

Overall, people living at Moorgreen had the capacity to consent to their care and treatment. However, some improvements were required to ensure the rights of people who had fluctuating capacity were fully respected. For example, one person had frequent checks completed on their bedroom to ensure their safety. Records showed that they were able to consent to this when they were well but were unable to consent as their mental health deteriorated. However, this decision had not been fully considered under the MCA to determine if room checks were in their best interests. We shared this feedback with the area manager and after our inspection visit they provided evidence that they had made the required improvements to ensure people's rights were respected.

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). DoLS were not required for anyone who was living at the service at the time of our inspection.

Heathcotes (Moorgreen) is situated in a purpose built premises. Consideration had been given to people's needs in the design of the building. For example, fixtures and fittings had been installed to reduce the risk of people harming themselves. Although this helped to ensure people's safety it had led to some areas, such as bedrooms and bathrooms, being clinical in appearance. Communal areas were more homely and had recently been decorated in bright colours. There was a communal area on each floor and a separate dining area which meant people had a choice of where to spend their time.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and caring in their approach. We saw staff were friendly and people appeared to be relaxed in their presence. One person told us, "Staff are caring and sit and talk to you." A relative described staff as, "Friendly and polite."

Staff were aware of people's needs and preferences. People told us they had good relationships with staff but commented that changes in the staff team and use of staff from other Heathcotes services had a negative impact on the development of trusting relationships. During our inspection, we observed that staff had a good knowledge of what mattered to people living at Heathcotes (Moorgreen) and had developed relationships with them. 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. Most staff had an understanding of people's emotional support needs. There was clear information in people's support plans about how people's past experiences impacted on their day to day wellbeing and staff demonstrated an understanding of this.

At our March 2017 inspection, there were some concerns about staff maintaining professional boundaries with people who used the service. This continued to be a theme at this inspection. One person's relative told us staff treated their relation "more like a friend," and said this had sometimes led to awkward situations. Another person's relative told us their relation had come to rely upon certain staff members. We spoke with the area manager about this who told us they had already identified this issue and said they were confident that recent changes to the staff team would resolve this.

People were involved in choices and decisions about their support. People told us they felt involved in decisions and 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. During our inspection we were made aware of recent occasions where people had not been fully involved in decisions about how they spent their time, this had been identified and the area manager was in the process of taking action to address the issues. People were offered the opportunity to get involved in the development of their support plans. One person told us, "I was really involved, much more than before (in previous home), I was asked if there was anything I would like to add."

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. Information leaflets were on display in the home and this was also discussed with people on an individual basis. No one was using an advocate at the time of our visit.

People were supported to develop and maintain their independence. The service provided at Heathcotes (Moorgreen) was focused on helping people develop the skills they needed to live more independently. We received feedback from a commissioner of the service who told us the staff team had worked with one person to build their skills, confidence and coping strategies which had enabled them to move on to more

independent living. They told us, "[Person] was also supported to fully engage with community resources and would go out independently most days. Their skills with their activities of daily living improved significantly, they were attending most appointments on their own, self-medicating and undertaking their own personal care and domestic chores." Positive risk taking was promoted to enable people to have as much independence as possible whilst ensuring their safety. For example, one person was supported to manage some aspects of their medicines independently. Their support plan contained information about how their independence could be increased further in the future.

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. We received some feedback from people's relatives and also saw records of instances where people's privacy had not been respected. We discussed this with the area manager who told us they were aware of this issue and were in the process of taking action to address this. We also saw that one person had requested an audio monitor for their bedroom to reduce the need for staff to enter. This had been provided and resulted in them having increased privacy.

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.

Good

Is the service responsive?

Our findings

Before people moved into the service an in-depth assessment of their needs was conducted by the therapy team, this was done in partnership with the person and other professionals involved in their care and support. This assessment, along with other information, was then used to develop people's support plans. Support plans contained detailed information about each person's individual needs and preferences, their level of independence and areas where support from staff was required. We saw support plans had been put in place ready for when people moved into the home to ensure staff could read them before providing support. Some improvements were needed to ensure support plans were updated to reflect learning from events and incidents. For example, records showed one person had become upset following contact with a relative; however, their support plan had not been updated to reflect this, or to provide guidance to staff on how to reduce the risk of this happening again. This meant there was a risk the person may receive inconsistent support. Despite this, we found overall, staff had a good knowledge of each person.

We recommend the provider reviews how learning from events and incidents is used to update support plans.

People were given the opportunity to discuss their wishes and preferences in relation to care at the end of their lives. A personalised approach was taken to this, taking into account the person's physical health and the potential impact of discussions about end of life care on people's mental health. Where people had chosen to discuss this it had been sensitively recorded in their support plans.

Feedback about opportunities for meaningful activity was mixed. Some people and relatives told us there was not always enough to do. One person said, "I do get bored, there is nothing to do." A relative told us, "[Relation] has not got enough to do." Another person told us that activities were sometimes cancelled due to staffing, they said, "We are regularly told there are not enough staff to take us out." Another person said, "It's boring anyway so if you can't have your walk to the shop its bad." Staff also commented that activities could be limited due to staffing and finances.

Where people were provided with opportunities for activity, staff told us and records showed, these were based upon people's individual needs and preferences. For example, one person's support plan specified the needed support to occupy themselves at specific times of the day and records showed staff engaged them in playing games and sat and chatted with them to prevent their mental health from deteriorating. Records showed people had the opportunity to take part in some community based activities such as, trips, groups and shopping and on the day of our inspection visit a group of people went out to the cinema. Staff also involved people in some activities related to the running of the home such as cooking and cleaning. We spoke with staff about how people spent their time and they explained that on some occasions the lack of activity was often down to the 'choice' of the person. We discussed activities with the area manager who told us they had already identified some issues which they were in the process of investigating. They also told us that recent changes in the staff team had impacted on the availability of staff, but added they were confident improvements underway would resolve this.

People's diverse needs were recognised and accommodated. The area manager provided an example of how the team supported one person to express their individual preferences. The area manager told us no one had any needs related to their culture or religion and added that people's diverse needs were assessed when they moved into the service and would be accommodated as required.

The service was meeting its duties under the Accessible Information Standard. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. We saw that information was displayed around the home in a format people could understand and accommodations had been made to other parts of the service to cater to people's needs. For example, an adapted form of Dialectical Behaviour Therapy was provided by the service. This took account of people's level of understanding to ensure that the therapy was accessible to them.

People were supported to maintain relationships with people who mattered to them. People's support plans included information about relationships that were important in their lives and we saw records to show that people were in regular contact with those who were important to them. There were no restrictions upon visitors to the service.

People were given opportunities to provide feedback about the service in a number of ways. Regular meetings were held with each person to enable them to share their views on different aspects of the service. Records of these meetings showed that areas such as, the home environment, activities, safety, complaints and health were discussed. In the majority of cases action had been noted against issues that had been raised. During our inspection one person told us they had a raised a concern with staff but nothing had changed. We discussed this with the area manager who told us they would look into this.

There were systems and processes in place for people to provide feedback and to deal with, and address complaints. People told us they would feel comfortable telling the staff if they had any complaints or concerns. Staff knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to their manager. Staff told us they were confident the management team would act upon complaints appropriately. There was a complaints procedure on display in the foyer, informing people how they could make a complaint. This was presented in a format people who used the service would understand. Records showed that no formal complaints had been made since our previous inspection.

Requires Improvement

Is the service well-led?

Our findings

During our March 2017 inspection we found some improvements were required to ensure the safety and quality of the service. At this inspection this continued to be the case.

The system to review, analyse and learn from incidents was not effective. This had resulted in a failure to identify, investigate and address concerning information in a timely manner. For example, we reviewed an incident record which documented that there had not been enough staff available on one occasion to ensure people's safety. As this was not reviewed by the registered manager, action had not been taken until staff raised concerns to the provider about this. The area manager told us information about all incidents and physical interventions were sent to the provider each month for review. We reviewed records of this and found that although this was effective in identifying increased numbers of incidents it did not constitute and in depth analysis of incidents. This meant opportunities to identify ways of preventing future incidents may have been missed.

There were systems and processes in place to monitor and improve the quality of the service; however, these were not always fully effective. The management team conducted regular checks and audits of areas such as, medicines management and maintenance. The management team also conducted 'out of hours' spot checks of the home to monitor the quality of the service and performance of staff. The regional manager conducted 'monthly provider visits' which assessed the quality of the service across a range of areas including care delivery, training and the environment. We looked at records of an audit conducted in early February 2018 and saw that it was effective in identifying some areas for improvement. For example, it had identified that support plans had not always been updated to reflect people's current needs, poor recording of staff debriefs and a failure to ensure records of physical interventions were reviewed and signed the registered manager. However, due to some changes in the staff team some of the issues identified had not yet been rectified. The service also had regular support from the provider's quality assurance team. We saw that some issues identified in a September 2017 audit had been addressed. For example, the audit had identified night staff did not have sufficient level of training to ensure the safe administration of medicines, at our inspection we saw this had been addressed. However, we did note some areas where improvements had not been made or sustained. For example, the September 2017 audit recorded there was limited evidence that people were involved in decisions about menus, this remained the case during our inspection. This audit had also identified the lack of manager review of incident records, again this remained an issue at our inspection.

The provider had not consistently shared information in an open and transparent way. After our December 2016 inspection, we imposed a condition to restrict admissions to Moorgreen, this remained in place at the time of this inspection. We had however, granted permission for admissions on a case by case basis. Upon arrival at Heathcotes (Moorgreen) we were informed the registered manager had been absent from the service for approximately three weeks. The provider had not informed us about the absence of the registered manager which meant we were not aware of this when considering recent admissions to the service. In addition to this, during the course of our inspection, we spoke with two different commissioners, both told us the provider had not informed them about the restriction upon admission to Heathcotes

(Moorgreen).

The provider had put interim management cover in place in the absence of the registered manager. Some people were unclear of who was in charge at the service. One person commented there had been a recent high turnover of staff which had caused people to feel unsettled. They said, "We need someone to take charge, I can count five staff members who have up and left." We discussed this with the area manager who told us meetings would be held in the near future to share information about the management and leadership of the home.

People had an opportunity to have a say in how the service was run. Meetings were held with each person on an individual basis. We saw records of these meetings which showed that they were used to discuss areas such as activities and complaints. People also had the opportunity to share their feedback in an annual satisfaction survey, this was distributed to people living at the home, families and professionals. We viewed the results of the 2017 survey, which were largely positive. The area manager told us the 2018 survey was planned to take place within the next few weeks.

Staff told us they were happy working at Heathcotes (Moorgreen) and were proud of their work. One member of staff told us, "All managers are approachable, it's a really good team to work for." Staff said they were given an opportunity to have a say in the running of the service in staff meetings. However, records showed staff meetings did not take place regularly. We discussed this with the area manager who told us they had identified this as an issue and were in the process of planning staff meetings. Despite this, staff told us they felt well supported and understood their roles and responsibilities. They were aware of their duty to whistleblow on poor practice and felt confident in raising any concerns with the area manager.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their most recent rating on their website. However, this was not displayed in the home. The area manager assured us action would be taken to ensure the most recent rating would be displayed. We checked our records which showed the registered manager had notified us of events in the home. 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.