Heathcotes Care Limited

Heathcotes Enright Lodge

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Heathcotes Enright Lodge is a residential care home service that can accommodate up to six people. The service can support four people in one shared bungalow and two other people in self-contained apartments. The service specialised in caring for people with learning disabilities, autistic people and people with complex mental health needs. At the time of the inspection three people were living at the service.

People's experience of using this service and what we found
People were not supported in a consistent way and since the last inspection there had been an escalation in incidents and injuries. People had care plans and risk assessments in place, but it was not clear that staff always had the opportunity, or time, to read people's updated care plans.

People were not always supported by staff who had the right training and experience. Staff retention continued to be a problem and the provider had drafted in staff from other services, and also used agency staff to maintain safe staffing levels. This did not help with the problem of consistent support.

People's living environment was generally clean and tidy. However, we notified the local council environmental health team about overflowing external waste bins which posed a potential health hazard.

Staff told us they did not feel supported by their managers and felt stressed and over worked at times. Not all staff had received the specialist training they required to support people safely; although most staff had received the provider's basic training.

People were supported to have enough to eat and drink. The food was seen to be appetising, although we found one person was not supported to have access to the snacks they preferred.

Staffing issues sometimes affected the ability to support people to attend community activities which they enjoyed. Staff received guidance from external specialist agencies on how to provide support to people; although some staff told us they did not agree with aspects of the advice and guidance received.

Some people's relatives told us it was difficult to obtain information from the care home about their loved one, and they wanted more information to be shared with them regularly.

People were protected from the risk of abuse by the provider's policies and procedure and staff knew how to raise concerns appropriately. People's prescribed medicines were managed and administered safely. We found that general COVID-19 precautions and procedures were in place and in line with current guidance.

The provider had engaged with other agencies and had an open approach to explaining about the problems they had been encountering at the service.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of the key questions; Safe, Effective and Well-led
The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, Right care, Right culture.
The care provided to some people did not always promote people's choice, control and independence. Care was not always person centred. The behaviours of leaders and care staff did not always ensure the people using the service led confident, inclusive and empowered lives. Inconsistencies in the support provided had a negative impact on some people which affected their wellbeing.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 9 August 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement, or inadequate, for the last three consecutive inspections.

Why we inspected
We received concerns in relation to the management of incidents and staffing levels. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has remained Requires Improvement. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

The provider continues to work closely with the local authority and specialist health teams to identify ways in which consistent and appropriate support can be provided. The provider is also working with local authority service commissioners to support a person to move into a more appropriate placement which may better meet their needs.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for

Heathcotes Enright Lodge on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people's safety, the care and treatment they receive, and the management of the service. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Heathcotes Enright Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Heathcotes Enright Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Our records showed the service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, the registered manager had left the service several weeks previously and the provider had not formally notified CQC, something which they are required to do by law.
The care home was being managed by the provider's regional manager as an interim measure.

Notice of inspection
This inspection took place on 29 and 30 September 2021 and was unannounced on both days.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to

complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with two people, who used the service, about their experience of the care provided. We spoke with six members of staff including the regional managers, senior care workers and care workers. We observed staff interactions with people who used the service.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We received feedback from two relatives of people who use the service. We also received feedback from seven staff members who worked at the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection the provider had failed to provide consistently safe care and treatment, maintain up to date support plans and learn lessons from incidents; which put people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Learning lessons when things go wrong

- Opportunities to learn from incidents continued to be missed. Since the last inspection there had been an escalation in incidents, and it was not clear if incidents had always been reviewed effectively. The provider appeared to rely on specialist external health agencies to identify lessons learned from incidents.
- Inconsistent support was a key factor in incidents. Although care staff told us inconsistency of staff approach was a primary cause of incidents occurring, this had not been addressed effectively by the provider. This increased the risk that people would receive unsafe care.

Staffing and recruitment

- Staff retention and turnover continued to be an issue. A staff member told us, "They simply don't have enough staff, and can't recruit people, because no one wants to come and work here." The manager used staff from the provider's other services, and agency staff to ensure staffing numbers were maintained at a safe level. However, they accepted this affected the consistency of support provided to people who had complex care needs.
- There was a lack of teamwork among staff. Staff were generally split into three teams. A staff member told us, "The staff teams are always falling out with each other. There is no consistency between the staff teams and between some of the staff in the teams. They just don't work together; they just fight with each other." This increased the likelihood people would receive poor care.
- Rota records were not always reliable. Rota sheets did not always identify which staff members were planned to cover a specific shift, and which staff members actually worked the shift. Details of which agency staff covered shifts were also not readily available from the rota records. Rota sheets should be an accurate record of who covered shifts at the service.
- Staff were safely recruited. The provider had processes in place to ensure that appropriate pre-employment checks were carried out. Quality audits were also in place to identify and rectify any staff recruitment record issues. This helped ensure staff employed were suitable to support vulnerable people.

Assessing risk, safety monitoring and management

● People's risks were assessed, and care plans were in place. However, when sections of a person's individual care plan were updated, the provider could not evidence they had ensured all staff had read and understood those updated sections. This increased the risk that people would receive inconsistent support.

● The provider had failed to register the care home with the local council environmental health/food safety department. We found no indications that food safety had been compromised. However, the inspector notified the local council who contacted the provider to discuss the requirements to register as a business which provides food to people.

● People's living environment was generally well maintained, and the provider carried out regular health and safety checks.

At our last inspection the provider had failed to effectively protect people from the risk of abuse. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. Care staff had received safeguarding training and understood how to raise concerns about care if necessary. This helped reduce the likelihood of abuse occurring at the service.

● Incidents were reported appropriately by care staff. The manager reviewed the completed incident forms and shared summaries of them with the relevant external agencies where necessary.

● The provider's safeguarding policies and procedures were appropriate. These guided care staff and managers in how to respond if any allegations of potential abuse arose.

Using medicines safely

● Some staff told us they did not agree with the administration of 'as and when needed' (PRN) medicines. For example, one staff member told us, "I don't agree with that. They are just drugging [person] because they can't deal with their behaviours. The PRN medicine is working better, but I still don't think that it is the right thing to do." The inspector discussed this with the manager who explained the use of PRN medicine was guided by advice from specialist external health teams; and its use sometimes led to a reduction in the severity of incidents and was being closely monitored.

● People received their prescribed medicines safely. Storage, administration and recording of medicines was safe.

● Staff received the necessary medicine administration training. Only senior staff administered medicines following training and competency assessments. This helped reduce the likelihood of errors occurring.

● Medicine errors were identified by the provider's quality assurance processes. When errors occurred, action was taken immediately to ensure the person's safety. Errors were reported and investigated appropriately. Action was taken to share any lessons learned, provide additional training, or carry out a staff disciplinary process if necessary.

● The service had policies and procedures in place to support staff knowledge about medicines and their safe administration to people.

Preventing and controlling infection

● There were lapses in good waste management practice. The external waste bins were overfull, with lids

open, and waste bags lying on the floor. Some of the waste bags on the floor appeared to contain food waste. This created an increased risk of rodent infestation. The inspector notified the local authority environmental health department. The provider told us they would arrange for increased waste bin collections to address the problem.

● We were assured that the provider was preventing visitors from catching and spreading infections
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People sometimes received inconsistent support from care staff. For example, a staff member told us, "The staff just can't cope with [person], and they don't follow the care plans. That makes the environment even less safe, because [person] needs consistent boundaries." The lack of a consistent staff approach had a negative impact on some people's wellbeing.
- People were not always able to obtain help when they needed it. A person's flat had a broken call buzzer. This meant they could not call staff if they needed urgent assistance when their 1:1 staff member was not with them. The provider told us they would arrange for a repair and that, in the meantime, staff would always be located immediately outside the person's flat if they were not inside the flat with the person.
- People had relevant assessments and care plans in place. Care plans included details of how people wanted care to be provided to them; where appropriate.

Staff support: induction, training, skills and experience

- Staff told us they did not feel safe and were not supported by their managers. A staff member told us their managers were, "absolutely no support at all. But I don't think there is much they could actually do. They don't really know how to support [person] either." This was cited, by some staff, as being one of the main reasons for the high staff turnover.
- Some staff had not received required specialist training. For example, an assessment identified a person should be supported by staff who had received a high level of safe restraint training. Most staff had received basic safe restraint training, but not enough staff had received the higher level of training required. This increased the potential that the person, or staff, would be injured. The provider told us they would arrange for additional training to be provided.
- Staff training requirements were monitored by the provider. A staff training matrix was in place which showed when training had been provided to staff and when refresher training was required.

Supporting people to eat and drink enough to maintain a balanced diet

- People were not always supported to have access to preferred food items which they liked to prepare themselves. A relative told us, "[Person] ran out of their favourite cereal and other items. I gave the staff a list of what I know [person] likes to eat. [Person] rang me a couple of days later to tell me that the staff had still not purchased any cereal for them." This limited the person's ability to independently prepare light meals and snacks.
- People were supported to eat and drink enough to stay healthy. We observed main meals were appetising and alternative menu options were readily available if a person preferred something different.

● People's specific dietary needs were understood by staff. Care plans were in place to guide staff about people's individual food allergies and dietary needs. This helped ensure people were offered food which was safe for them.

Staff working with other agencies to provide consistent, effective, timely care

● People were not always supported to consistently attend activities which were important to them. For example, on one occasion, a person did not attend college because the provider had no staff available who could drive the care home's vehicle. The person was not told about the transport problem in a timely manner by staff. That meant they were left ready and waiting to go to college, for several hours, until a staff member finally told them they could not attend on that day. This caused the person anxiety and distress which could have been avoided.

● The provider received support and guidance from external specialist health teams. As a result of ongoing concerns raised by the local authority and health teams, specialist guidance was provided to the service about how to work with people whose behaviours were sometimes challenging for staff to support. We saw staff following that guidance, although we received feedback from some staff who told us they disagreed with aspects of it.

Adapting service, design, decoration to meet people's needs

● The internal and external environment had been developed to meet people's complex behavioural needs and safety. Some of the people living at the service occasionally damaged their living environments when anxious or upset. Generally, repairs were carried out in a timely manner to ensure people's living environments continued to be safe.

● A person told us they were happy with their living environment. We saw they had personalised it and that it contained personal belongings which were meaningful to them.

Supporting people to live healthier lives, access healthcare services and support

● People were supported to attend routine and emergency medical appointments. This ensured they received any medical and health care treatment they required.

● People were encouraged to take exercise to stay healthy. Although the COVID-19 pandemic had limited the options available to people, during certain periods of the 'lock down', people were supported to go out for walks in the community, with staff, when safe for them to do so.

● People had health care plans in place. Individual health care plans guided staff on how to monitor and support people's health. This helped people to stay healthy.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People had care plans and risk assessments in place. These contained details of best interest decisions which had been taken on any issues which the person was not able to decide for themselves.
● Necessary restrictions on people's liberty were appropriately authorised. Restrictions had been assessed and authorised in line with the DoLS. Any conditions on the authorisations were identified in people's care plans and we found evidence they were being complied with.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the service was not effectively managed. This resulted in inconsistent care and support for people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The registered manager had left the service several weeks prior to the inspection. The provider had failed to formally notify CQC about their leaving; which is something they are required to do.
- There was a continuing theme of staff not feeling supported in their roles by their managers or the provider. A staff member told us, "Managers can be really quite rude to staff. They have been heard talking loudly about staff in a negative way. But I know that they are very stressed."
- Incident reports were reviewed by the manager and some inconsistencies of staff support were occasionally identified. Opportunities to learn from incidents were sometimes missed and effective action had not been taken to improve the consistency of care provided by staff. This meant people continued to be at increased risk of receiving poor care.
- The provider had quality monitoring systems and processes in place. However, ongoing staff vacancies, inconsistencies in support being provided to people, and difficulties in ensuring enough appropriately trained staff were available on each shift meant the service was not able to make improvements necessary in a timely manner.
- The manager reviewed the content of incident reports, completed by staff to monitor the standard of recording. They had requested some be amended so the information was written in a more objective and factual way, rather than as a subjective description of events. Unfortunately, some staff interpreted that as an attempt to hide things. We reviewed several incident reports and found that not to be the case.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Several staff told us they were dissatisfied with management of the service, that they did not feel listened to and that they felt stressed and over worked. A staff member told us, "There isn't really any training for staff on how to actually support [person], they all just try to find their own way, and that makes things inconsistent."

● Staff told us managers were out of touch with what was happening at the service. A staff member told us, "Managers are just trying to stick to the rules, but they don't really understand the residents like we do." Differences of opinion between the managers and staff, and between different groups of staff, limited the ability of the service to achieve good outcomes for people.
● People did not always achieve good outcomes from the support they received. The manager told us a person required specialist counselling support to help them recover from previous traumatic life events, and they had contacted external agencies to request support. A staff member also told us, "[Person] needs therapy to deal with their trauma and that is not happening. We are minimum wage support workers, not therapists. We are not trained to do that type of work."
● A person told us they liked the staff who supported them. They told us, "My staff have been okay with me." They also told us they liked going out into the community with the staff.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● People's relatives were not always kept informed about important issues. A relative told us, "Getting any information out of Enright Lodge is like getting blood out of a stone sometimes. They don't keep me up to date, and they should do as there are things I have to know."
● With the exception of the notification about the registered manager leaving, the provider had informed CQC about other incidents which they are required to formally notify us about. This helps us to monitor the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's equality and diversity support needs were identified. People's care plans contained details of how the person wanted to be supported.
● The manager told us they had recently changed the way the rota worked, after consulting with staff. This was because they identified a need to shorten the length of some long shifts to reduce the strain on staff and provide more flexibility. Some staff told us this had improved things, other staff told us it had worsened the impact on staff.

Working in partnership with others
● The provider had been open with other agencies about the difficulties they were having at the service. The manager had complied with the local authority requests for ongoing updates and status reports.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that care and treatment was always provided in a safe way for service users. Action was not always taken to mitigate the known risks to people of receiving inconsistent support; and the staff providing care or treatment to service users did not always have the training, skills and experience to do so safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have effective systems and processes in place to assess, monitor and improve the quality and safety of the services provided. Known risks to people, due to inconsistency of support, were not effectively addressed by the provider. This had a negative impact on the health, safety and welfare of service users and others who may be at risk.