Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Heathcotes (Mansfield)

11 Lindhurst Lane, Mansfield, NG18 4JE

Date of Inspection: 14 March 2013

Date of Publication: April 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Heathcotes Care Limited
Registered Manager	Ms. Amelia Hallas
Overview of the service	Heathcotes (Mansfield) is owned and managed by Heathcotes Care Limited. The home is situated in a residential area of the town of Mansfield in Nottinghamshire and offers accommodation for to up to five adults with a learning disability.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 14 March 2013, observed how people were being cared for and talked with staff.

What people told us and what we found

We did not speak directly with any people who used the service as two of the three people were not present. The third person said they did not wish to speak to us.

In order to complete our inspection, prior to our visit we reviewed all the information we had received from the provider. During the visit we spoke with one care worker, the deputy manager and the regional manager. We also looked at some of the records held in the service including the care files for three people. We carried out a brief tour of the building and observed briefly how staff supported one person, but we saw that the person was unsettled (who was unsettled) so we did not continue.

We found people were involved in the running of the home and they were respected and treated with dignity.

We found people were safeguarded from abuse and the staff team were supported through training. The provider had suitable systems to record information needed for the running of the service.

However, we also found people's care had not been properly planned for.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 23 April 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our

decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People expressed their views and were involved in making decisions about their care and treatment. The deputy manager told us people who used the service were encouraged to make decisions for themselves, and about their daily routines. We saw one person who used the service got up when they chose during the morning and the deputy manager said this was the time they normally liked to get up. The other two people who used the service had gone on a visit with another member of staff which we were told they had wanted to do.

The deputy manager told us they had planned to introduce keyworker meetings, where an identified staff member would work closely with each person who used the service. The deputy manager said this would provide opportunities to discuss people's care and support with them and enable people to make decisions and choices about these.

The deputy manager told us people were supported to choose their menu's and enjoyed going shopping for their food. A staff member told us, "We do a meal planner with them."

The deputy manager also said people were able to choose what activities they wanted to do and could suggest any specific things they wanted for the home. Two people had gone out to visit another of the provider's homes where there were some people they knew. The regional manager told us the two people who had moved into the home first had been involved in selecting the pictures and other furnishings and chose where they would be placed. The regional manager pointed out a motorbike picture they said one person had chosen and decided where they wanted it putting up.

We heard staff talking about a person having requested to rearrange some garden items so they could play football, and the staff were planning to do this. The regional manager told us some people were interested in growing their own vegetables and they were going to create a vegetable patch.

The deputy manager said one of the people who used the service had asked about having house meetings. The deputy manager said these would be introduced but had not yet planned when. One person who used the service had said they would write the minutes of these meetings. The deputy manager said these meetings would be for the people who used the service to run and they could discuss what they wanted. The deputy manager also said they could invite staff to attend the meetings if they wanted to.

The deputy manager said if a person who used the service asked for something they would assess whether this was possible to do. A staff member told us, "They (people who used the service) definitely have a say."

People were supported in promoting their independence and community involvement. The deputy manager told us one person who used the service had recently mowed the lawn and also said people helped with the chores for running the house. The manager told us some people who were able to have their own bank accounts and were supported to manage their finances.

The deputy manager told us people were encouraged to personalise their bedrooms and could put up pictures and other personal items. We saw one person used a key to lock their bedroom door when they came out. We also saw keys in the two vacant rooms and the deputy manager told us everyone was provided with a key to their room.

Each person had their own room with an en-suite shower room. We saw there was lockable furniture in the vacant rooms and the deputy manager said each room had recently been provided with this furniture.

The deputy manager told us they had spoken to staff about signing up to become dignity champions and they had all agreed to do so. This is a government initiative which aims to put dignity at the heart of care services. The role of dignity champions is to stand up and challenge disrespectful behaviour. A staff member told us the deputy manager had spoken to them about becoming a dignity champion and they were keen to do so.

The provider may wish to note that people's diversity had not always been considered in the care plans we saw. This included a lack of reference to one person's culture and religion. We mentioned this to the deputy manager who said they would make sure diversity issues were addressed in people's care plans.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not experience care that was planned in order to meet their needs and protected their rights.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Care was delivered in a way that ensured people's safety and welfare. A staff member told us, "We always make sure people get everything they need. They have the activities they want. We see if they want to do something together or do something individually with staff."

The deputy manager told us one person who used the service had said they wanted to get a job. The deputy manger told us the person was preparing a curriculum vitae (CV) and staff were supporting them with this.

The deputy manager told us they had access to support teams who would come to the home if they were requested to. The support teams consisted of other workers employed by the provider, including a behaviour specialist, the regional manager and managers of other homes run by the provider in the area.

The deputy manager told us they had called a support team out the previous day to support some of the people who used the service who were having some difficulties. The deputy manager said this was a good resource because they were workers who had known the people who used the service for some time and had good relationships with them.

However, we also found that people's care was not planned and delivered in line with their individual care plan. We looked at the care files for the three people who used the service. These mainly contained information from the people's previous placement, which was another home owned and managed by the same provider. The deputy manager told us the people had brought these files with them when they moved to the home and no new plans had been prepared since they had moved to this home. We did not see any evidence to show these plans had been reviewed, and we saw they still referred to their previous placements. This meant some of the information was out of date. An example of this was a care plan for cooking in the kitchen.

The deputy manager showed us a care plan audit form which they said they would be introducing, but the care plans had not been audited since the people had moved to the home.

There was a sheet for staff to sign to show they had read and understood people's care plans. We noted that some of the staff had signed these, but there were some staff who had not done so. The deputy manager showed us the communication book where they had left two messages reminding staff they should read these and sign them to show they had done so. This meant some staff were not finding out about people who used the service and how to meet their needs.

We saw two people's individual health action plans which were meant to record details of each person's health needs and any treatment or appointments. We saw these had not been updated since the person had moved to this home and still contained their old addresses. This meant people's health needs were not being fully considered.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

The deputy manager showed us the provider's whistle blowing policy and guidance they issued for safeguarding. Whistle blowing is the term used when an employee has a duty to report any wrong doing that take takes place at work. We saw the safeguarding guidance contained a reference to outdated legislation and the regional manager contacted us after the inspection to inform us this had been corrected. A staff member told us they knew about the provider's safeguarding and whistle blowing policies and knew how to raise a concern if they had one.

The deputy manager said they had requested the local authority send them a copy of their safeguarding procedures but these had not yet arrived. The deputy manager said in the meantime they could access these on the internet if they were needed.

The deputy manager told us they knew how to make a safeguarding referral to the local authority. The deputy manager also said they knew how to make a Deprivation of Liberty Safeguards (DoLS) referral and although they had not needed to at this home they had done so at a previous place they worked. DoLS ensure scrutiny and the right of appeal in situations where a person may need to receive treatment or have actions taken in order to keep them safe which amounts to a deprivation of their liberty.

The deputy manager told us there were safeguards in place to prevent any abuse of people's finances. This included a record kept of any time a person's bank card was taken out of the home and receipts were kept for all transactions. Financial records were signed and witnessed by two staff.

People who used the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements. At one point during the inspection the regional manager took appropriate action to reduce potential risks and protect the safety of one person and the inspector.
We saw from staff training records all staff completed training on Non Abusive Physical Intervention (known as NAPPI) for managing any challenging behaviour safely. A staff member told us they had completed the first part of this training and were waiting to attend the second part.

A staff member told us they completed an incident form after any untoward incident and showed us the incident form file. The staff member said they had completed two incident forms recently and we saw these in the file.

The deputy manager said part of this incident form required them to go through a de-briefing with the staff member to see if things could have been handled in a different way that would have prevented the incident from occurring. The deputy manager showed us one incident form where they had identified a different approach may have prevented an untoward incident taking place.

The provider may wish to note the incident forms did not have an index system to help cross reference them to other records or identify if one or more forms were missing.

The deputy manager showed us a record book that would be used to record any incidents where restraint might be used. The records showed there had been no incidents of this nature at the home.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care safely and to an appropriate standard.

Reasons for our judgement

We found the provider gave new care workers an induction to explain their role to them. The deputy manager showed us the provider's induction programme for new staff taking up employment with them. They said the induction programme included working through the common induction standards prepared by Skills for Care which is a national organisation that supports employers in the development of people working within social care.
The deputy manager, who was also new in post, said they were still having an induction and was been given support whilst they settled into their role. The regional manager told us the registered manager is based at another home and was proving support to the new deputy manger. The regional manager said the deputy manager is responsible for the day to day running of the home and would apply to be the registered manager once they had completed their induction.

A recently employed member of staff told us they had found the induction helpful and were still working their way through the common induction standards. The staff member said when they finished these they would bring in the workbooks they had completed and discuss them with a manager. The staff member also said they felt they were learning as they went along.

The deputy manager told us there were two staff who were due to bring their induction workbooks in to go through with them and provide feedback on the work they had done.

The provider made arrangements for care workers to receive appropriate training. The deputy manager showed us the staff training matrix and this showed all staff received the training the provider had identified they needed to carry out their duties. This included training on safeguarding, moving and handling, the Mental Capacity Act (2005) Non Abusive Physical Intervention (known as NAPPI).

The deputy manager said they had started to put a supervision and support structure into place to provide staff with the support they need to carry out their duties. This included individual meetings to discuss staff work performance and holding staff meetings.

The deputy manager said there was a team leader on duty each shift and the provider

operated an on call system for the homes in the area if further advice or support was needed. The deputy manager said they felt well supported and any requests they made for support were responded to promptly. We saw there was a set of the provider's policies and procedures in the office.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment.

Reasons for our judgement

During the inspection we saw various records were being kept. This included a record of people's finances, staff rotas, staff training records and daily notes about people who used the service. There was a diary to record any appointments and other commitments for the running of the home and a maintenance book to record any repairs that need attention. We saw records were kept securely and could be located promptly when we asked for them.

The deputy manager also told us they had access to the provider's database where a lot of records were kept, including the provider's quality assurance system.

The deputy manager told us that since they had taken up their employment they had been finding out about the systems the provider had in place and planning other systems and records they wanted to keep. The deputy manager showed us some hardback writing books they had purchased to keep records of meetings and any compliments or complaints they received.

The deputy manager said as this was a new service and they were new in post they were "getting systems up and running" and would be reviewing and amending these as they went along. A staff member told us they had been told about the importance of recording and knew the principle "If it wasn't written down it didn't happen."

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: People did not have care plans prepared detailing the care and support they would receive in this home. Regulation 9(1)(b)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 23 April 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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