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The Herons

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 The Herons on 30 April 2018. The Herons 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. The Herons accommodates up to three people in one building. On the day of our inspection, three people were living at the home; all of these were people with support needs related to mental health conditions. This was the first time we had inspected the service since they registered with us in May 2017.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks associated with people's behaviour were not always effectively identified, assessed or managed. There was a lack of detailed risk assessment and risk assessment processes were not robust, this placed people and staff at risk of harm. The approach to risk management was not proactive. Environmental risks were not safely managed, action had not been taken to protect people from the risk of scalding and fire and this placed people at risk of serious harm. The registered manager took swift action to address this.

There were enough staff to meet people's needs and ensure their safety; however, due to a lack of information about physical intervention we were not assured there would be enough staff available in the event of a crisis. Safe recruitment practices were followed. There were systems and processes to minimise the risk of abuse. People received their medicines as prescribed. The environment was clean and hygienic.

People's rights under the Mental Capacity Act (2005) were not respected at all times. This meant we were not assured that decisions made on behalf of people were in people's best interests or the least restrictive option. Applications to lawfully deprive people of their liberty had not been made.

Care and support was not always properly planned and coordinated when people moved between different services. People were supported to attend health appointments and received support with specific health conditions. Staff had enough training to enable them to effectively meet people's individual needs and they were provided with regular supervision and support. People were supported to have enough to eat and drink; however, more information was required to ensure risks with eating and drinking were managed safely.

People told us staff were kind and caring. Staff respected people's privacy and treated them with dignity. People were involved in day-to-day decisions about their care and support and had access to advocacy services if they required this to help them express themselves.

Staff had a good knowledge of people's support needs; some improvements were required to support plans to ensure people received consistent support. People had some opportunities for meaningful activity; however, these were limited. People were supported to maintain relationships with those who were important to them. There were systems in place to respond to concerns and complaints.

Systems to ensure the quality and safety of the service were not comprehensive or effective. This had resulted in areas of concern not being identified prior to our inspection and placed people at risk of harm. Timely action was not always taken in response to known issues. People and staff were given the opportunity to provide feedback and make suggestions about the running of the home.

This was the first time the service had been rated as Requires Improvement. During this inspection, we found three breaches of the Health and Social Care Act 2008 regulations. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

People were not always protected from risks associated with their care and support. Environmental risks were not safely managed.

There were enough staff to meet people's needs and ensure their safety. Safe recruitment practices were followed.

There were systems and processes to minimise the risk of abuse.

People received their medicines as prescribed. The environment was clean and hygienic.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights under the Mental Capacity Act (2005) were not respected at all times.

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

People were supported to attend health appointments and received support with specific health conditions.

Staff were sufficiently trained to enable them to effectively meet people's individual needs. Staff were provided with regular supervision and support.

People were supported to have enough to eat and drink.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring. Staff respected people's privacy and treated them with dignity.

People were involved in day-to-day decisions about their care

and support and had access to advocacy services if they required this.

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 were supported to maintain relationships with those 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 consistently well led.

Systems to ensure the quality and safety of the service were not comprehensive or effective.

Action was not always taken in response to known issues.

People and staff were given the opportunity to provide feedback and make suggestions about the running of the home.

The Herons

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, to look at concerns we received about the quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was prompted, in part, by notification of an incident, following which, a person died. This incident is subject to a coroner's inquest and as a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about risk management. This inspection examined those risks.

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, which 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 key information about the service, what the service does well and improvements they plan to make.

The inspection was undertaken by two inspectors. During our inspection visit, we spoke with two people who lived at the home. We also spoke with three members of care staff and the registered manager. In addition, we spoke with three health and social care professionals involved with the home.

To help us assess how people's care needs were being met we reviewed all, or part of, all three people's care records and other information, for example their risk assessments. We also looked at the medicines records of all three people, four staff recruitment files, training records and a range of other 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.

After our inspection visit, we asked the registered manager to send us a copy of various records, policies and procedures, which they did prior to this report being completed.

Requires Improvement

Is the service safe?

Our findings

Risks associated with people's behaviour were not always effectively identified, assessed or mitigated. There was a lack of detailed risk assessment and risk assessment processes were not robust. Although support plans included some risk assessments, they were basic and required more detail to ensure staff had access to sufficient information about risk management of individual risk. For example, one person sometimes placed staff and others at risk due to inappropriate behaviours. Although there was a risk assessment and support plan in place, which had control measures related to the gender of staff, this had not been updated to reflect learning from recent incidents where staff had been placed at risk regardless of gender.

Some risks had not been identified and therefore had not been assessed and mitigated. For example, records showed one person had a recent history of violence towards others, and of attempting to cause serious harm to themselves. No risk assessments had been conducted in these areas and their support plan did not contain sufficient information for staff about the risks or how to manage them. In addition, there was no information about whether physical intervention may be needed to ensure the safety of the person and others. Records showed this had been required in previous settings, but the need for this had not been considered at The Herons. This meant there were no details about what physical interventions could be used in a crisis or how many staff may be required to safely support the person. Staff told us another person was known to put themselves at risk of harm by attempting to use household items as a substitute for illicit drugs. There was no information about this in their support plan and the risks this posed to the person had not been assessed. This failure to conduct adequate risk assessments placed people at risk of harm.

In addition to the above, the environment increased the risk of people's behaviours escalating. For example, one person's support plan stated they disliked crowded places and loud noise. The Herons was small with limited communal areas and throughout our inspection there were periods where music was played loudly and was able to be heard throughout the house. The impact of this on the person and potential risks had not been considered.

The risk assessment system used at The Heron's did not facilitate safe and effective care delivery. Risk assessment forms were basic; the likelihood and severity of risks were not rated, so the level of risk was unclear. In addition there was no consideration of the level of risk remaining after control measures had been put in place. This meant it was not clear if the risk reduction measures were effective in reducing the risk. Following our inspection visit, the registered manager provided us with alternative risk assessments which were more robust. However, these still did not cover keys aspects of some people's care and support.

The approach to risk management was reactive rather than preventative. The registered manager told us the provider had recently made a decision not to continue with physical intervention training, as they had not had to use it. Although staff had physical intervention training at the time of our inspection we were concerned that once this training expired staff would not have the skills required to support people safely. People's support plans stated that in the event of a crisis, staff should move to a place of safety and call the police. However, this was not possible in certain scenarios. For example, a recent incident record documented one person had got into a 'struggle' with staff and had blocked them in a room meaning staff

were unable to move to a place of safety. We remain concerned that staff would not have the required skills or training to safely deal with crisis situations.

There was a system in place to review and learn from accidents and incidents; however, people's support plans were not routinely updated with learning from incidents. Although we saw action had been taken as a result of incidents, such as contacting health professionals and reviewing individual staff performance, support plans and risk assessments had not been amended to reflect learning. For example, records for one person documented two occasions when they had placed themselves at risk of harm by running out in front of cars. Despite this, their 'road skills assessment' was blank and their support plan did not contain any information about how to manage this risk. This meant there was a risk people may receive inconsistent or potentially unsafe support.

People were not protected from risks associated with the environment. Water temperatures were above the Health and Safety Executive (HSE) recommendations of 44°C for health and social care settings, this exposed people to the risk of scalding. Although hot water temperatures were regularly monitored, action had not been taken when it was identified water was too hot and monitoring was not comprehensive. Monitoring records of water temperatures showed these were often above 50°C. This was still the case during our inspection. The registered manager told us they had discussed the potential of valves being fitted to reduce water temperatures, with the provider. However, a decision was taken not to install these. No risk assessment had been put in place to account for the fact there were no temperature controls. People living at the service were at increased risk of scalding due to their fluctuating mental capacity, mental health and history of self-injurious behaviours. Following our inspection visit the registered manager told us, action had been taken to fit values to reduce the water temperatures to a safe level; however, it remains of concern this had not been addressed before our inspection.

People were not adequately protected from the risk of fire. The home had a no smoking policy, which stated people could only smoke outside. Despite this, staff told us and records showed, that all three people were known to smoke in their bedrooms. The registered manager told us one person's carpet had been replaced three times due to cigarette burns and a member of staff told us the person smoked in their room, "every day." Assessments of the risk of people smoking in their rooms had been conducted; however, control measures were not sufficient to reduce the risk of fire. This posed a serious risk to the health and safety of people living at the home and staff. Following our inspection visit, the registered manager told us action had been taken to install cigarette smoke detectors; however, it remains of concern this had not been addressed before our inspection.

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

Processes were in place to minimise the risk of people experiencing avoidable harm or abuse. One person told us they felt safe. Staff had up to date training in safeguarding adults and they were knowledgeable about indicators of abuse and knew how to respond should they have any concerns. Staff felt confident any issues they reported would be acted on appropriately. The registered manager was clear about their responsibilities to protect people from the potential risk of abuse. No safeguarding referrals had been made; however, the registered manager was aware of the process for this.

There were enough staff available to meet people's needs and ensure their safety. People living at the home told us there were enough staff and this view was also shared by staff. Staff told us staff were deployed from other local services owned by the provider to cover short notice absence when needed. We reviewed rotas and found that, overall, there were enough staff on shift. Two or three staff were on most day shifts to ensure

people received their one to one support. There was one member of staff on at night and they were supported by an on-call manager who could be contacted by phone in the event of an emergency. However, due to the lack of information about physical interventions in care plans we were unable to ascertain whether staffing levels would be safe in the event of a crisis requiring staff to physically intervene.

Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal record checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

Overall, medicines were stored and managed safely. Medicines systems were organised and medicines records were completed to demonstrate that people had been given their medicines as prescribed. However, there were unexplained gaps on the medication records for one person and we found an error in dosage of another medicine. We looked in to this and found they were recording errors and had not had an impact upon people. Where people were prescribed medicines to be used 'as needed', there were no protocols in place to guide their use. For example, one person was prescribed an 'as needed' medicine to reduce the side effect of other medicines, but there was no guidance for staff as to when this would be needed. This meant there was a risk the person may not receive their medicine when needed. We shared these concerns with the registered manager who informed us they would take immediate action to address this.

Adequate hygiene practices were followed and overall the environment was clean and hygienic. Staff told us they had access to personal protective equipment, such as gloves. We saw there were systems in place to assess and ensure the safety of the service in areas such as fire and legionella. There were personal emergency evacuation plans in place detailing how each person would need to be supported in the event of an emergency such as a fire. There was an up to date legionella risk assessment and environmental risk assessments in place.

Requires Improvement

Is the service effective?

Our findings

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. We checked whether the service was working within the principles of the MCA.

People's rights under the MCA were not always protected, as the Act had not been correctly applied to ensure decisions were made in people's best interests. Mental capacity assessments had not been completed in all required areas. This meant people's capacity to consent to restrictions on their freedom had not been formally assessed. One person had restrictions upon them, such as restricted access to the kitchen. Staff also controlled their money and a medicine self-administration assessment documented they were not safe to manage their own medicines. There was also evidence in records to demonstrate that restrictions placed upon them had resulted in the person's behaviour escalating. Despite this, the person's capacity to consent to the restrictions imposed upon them had not been assessed. This meant we could not be assured that decisions made on their behalf were the least restrictive option and did not respect people's rights.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications for DoLS had not been made as required. The manager told us no DoLS applications had been made for anyone living at The Herons. However, there was one person who lacked capacity to consent to restrictions on their freedom. The registered manager told us they had not applied for a DoLS for this person as they had one to one support. This demonstrated the registered manager did not have an adequate understanding of DoLS and did not assure us that the necessary steps would be taken to ensure people's rights were protected.

The above information was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care and support was not always properly planned and coordinated when people moved between different services. Before people moved into The Herons, the registered manager and staff team visited people to get to know them and to conduct assessments to ensure the staff team could meet their needs. This information was then used to develop support plans. During our inspection, we reviewed the support plan for one person who had recently moved in to the home. We found their support plan and risk assessments lacked important information. The registered manager told us this was because they were still learning about the person. However, we spoke with a health and social care professional who told us the staff team had been in contact with the person and their previous staff team for a period of months and so had access to information required to complete a robust support plan. Furthermore, we found important information in

old assessments, which had not been included in the support plan. This failure to ensure coordinated transitions between services placed people at risk of harm.

People received effective support with their day-to-day health needs. We saw records of contact with health professionals in people's support plans, which showed people, were supported to access the GP and other health professionals, such as dentists and opticians as necessary. Records showed the registered manager and staff were aware of which health and social care agencies to contact to ensure that people continued to receive care and treatment for their current and changing health and social care needs. 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. People also had their health needs detailed in their support plans.

People told us they felt staff knew what they were doing. Records showed staff 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, first aid, health and safety and medicines management. The registered manager told us staff were also provided with additional specialist training where there was a need, such as specialist mental health training. New staff were provided with an induction period when starting work at the service, this included training and shadowing more experienced staff. New staff were working towards obtaining 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 and 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.

The registered manager told us, in the PIR, that all staff received equality and diversity training and this was also discussed in team meetings. This meant staff had the knowledge to identify and protect people from discrimination.

People had enough to eat and drink. People told us they had access to plentiful supplies of food and could prepare their own food. Staff and the registered manager told us people living at the home chose what they wanted to eat on a daily basis. People were involved in preparing and cooking meals. Staff told us they tried to encourage healthy options, but said that they always respected people's choices, even if it was an unhealthy choice. 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. This meant staff did not have adequate information about the severity of the allergy or what to do should the person experience an allergic reaction.

The Herons is situated in a residential property, which has been adapted to accommodate the service. There were two bedrooms and an office upstairs and a third bedroom, small lounge and communal kitchen downstairs. People also had access to the garden. Staff told us that only one person used the lounge, others spent time in their bedrooms or in the community. One person told us they do not use the lounge as it 'belongs' to another person who lives at the home. They also commented on loud music being played in the lounge and we observed this was clearly audible from their bedroom. Furthermore, the environment did not promote people's privacy, the lack of communal areas meant that, other than their bedrooms, people had very limited space to spend time with friends, family or visiting health and social care professionals. A member of staff told us, "It's hard to give people space here as it is a very small house." We also observed there was no covered smoking area, people were not allowed to smoke in the house so did so in the garden, but there was no shelter from poor weather. This may have contributed to the problems with people smoking in the house. The service manager told us they were planning to extend the property to provide more communal spaces.

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, "Yes staff are good to me."

Staff were aware of people's individual needs and preferences. People's support plans recorded their preferences for how they were supported along with their history, likes, dislikes and what was important to them. Most staff had insight into people's mental health conditions and used this to inform their care and support. One member of staff told us, "All people here have the same condition on paper. But they are all so different." There was information in people's support plans about how people's past experiences affected their day-to-day wellbeing and most staff demonstrated a good understanding of this.

Overall staff were friendly in their approach, yet maintained professional boundaries with people. However, we noted language used by some staff was overfamiliar and may have resulted in people misinterpreting the nature of relationships. For example, during our inspection we heard staff addressing people as 'babe'. This was a particular concern as one person was known to misinterpret relationships and this could lead to them placing people at risk. We spoke with the registered manager about this who assured us they would address this with the staff team.

People were involved in choices and decisions about their support. A member of staff told us, "People have choices, for example, two people stay up most of the night, that is their choice." People told us that, where possible, they were involved in decisions and we saw staff checked with people about their preferences for support. Staff we spoke with had an understanding of their role in ensuring that people had choice and control. People were offered the opportunity to get involved in the development of their support plans. Some people had chosen not to be involved in the development of their support plan and where this was the case, this was clearly recorded.

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 available to people 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. We saw and records showed people were encouraged to get involved in domestic tasks, such as cleaning and cooking. Staff discussed people's goals with them and these were recorded in their support plans. The registered manager told us one person had expressed a desire to attend college and they were in the process of finding suitable courses for them. Another person wanted more independence when out in the community. The registered manager told us they had worked with social care professionals and staff to enable the person to gain more independence. They told us they had also considered how to ensure the person was not subject to discrimination in the community, for instance, by staff not wearing their name badges so as not to draw attention to them.

Overall, 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 respected people's wishes to spend time alone. One person sometimes behaved in a way that compromise their dignity. We spoke with a member of staff about this, who told us staff always reacted quickly to prompt them to maintain their dignity. In addition, 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

Each person who used the service had an individual support plan. Most support plans were clear, personalised and contained detailed information about people's preferences and how best to support them. However, we found one support plan lacked detailed information. The registered manager told us action would be taken to rectify this. We also found action had not always been taken to ensure people's preferences were met. For example, one person's support plan documented they had a passion for films. However, they told us their television had not worked since they moved in. This meant they had to watch films on their phone. We discussed this with the registered manager who told us they would address this. Despite this, we found overall, staff had a good knowledge of each person.

People were offered some opportunities to take part in social activity; however, for some people this was more limited. People's feedback in this area was mixed, while one person told us they had enough to do another person told us they felt they did not have anything to do. Staff told us it was hard to engage some people in meaningful activity as they were very 'solitary' and preferred to spend time alone. Records showed one person had a structured programme of activity and was out most days, whereas another person chose to spend a lot of time with friends and family. Staff and the registered manager told us they had previously organised day trips, visits and activities but uptake was poor and most people chose not to take part in any organised activity.

Although the service was not supporting anyone who was coming toward the end of their life at the time of our inspection visit, people had been offered the opportunity to discuss their wishes for the end of their lives and this was recorded in their support plans.

People's diverse needs were recognised and accommodated. When people moved into the home, they were given the opportunity to discuss their individual needs, relating to their culture, religion and sexuality. The registered manager told us people's individual need were accommodated as required. For example, one person living at the home enjoyed specific cultural foods and they were supported to cook these meals. This meant people could be assured their diverse needs would be catered for.

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. The registered manager was aware of their duties and told us they would ensure people's needs were catered for in the future if required. At the time of our inspection, no one had any information access needs.

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 home.

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 available to people which detailed how they could make a complaint. Records showed that no formal complaints had been made since the home was registered in 2017.

Requires Improvement

Is the service well-led?

Our findings

It is of concern that a number of risks to the health and safety of people living at The Herons had not been identified prior to our inspection. Although audits had been conducted by the registered manager and the provider, a number of concerns found during our inspection had not been identified or addressed and consequently action had not been taken to safeguard people from harm.

Audits were not comprehensive which meant concerns about the safety of the service were not identified. For example, there were systems in place to check the water temperatures to protect people from the risk of scalding. However, these checks did not include the showers or baths. As a result, we found the temperature of showers exceeded the HSE recommendations and placed people at risk of scalding. The failure to ensure robust, comprehensive audits placed people at risk of harm.

Systems to ensure the safety and quality of the service were not fully effective and did not ensure action was taken to address serious concerns. We reviewed recent audits conducted by the registered manager and provider. These had not identified the concerns related to risk management and the implementation of the MCA identified at our inspection. Consequently, no action had been taken to address these shortfalls. This failure to ensure effective governance systems placed people at risk of receiving unsafe support that did not respect their rights.

Where areas for improvements had been identified, the provider had not always taken action to ensure people's safety. For example, records of staff meetings and audits showed that there had been concerns about fire risk due to people smoking in their bedrooms since January 2018. Despite this significant risk to people, action was not taken to install cigarette smoke detectors until after our inspection visit. The failure to take timely action meant people were placed at risk of harm for a prolonged period.

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

There was a registered manager in post at the time of our inspection; they were also manager of three other services operated by the provider. They told us they visited the service regularly and were passionate about the home, staff and people living there. The provider had also recently employed a business development manager to support the registered manager and ensure the quality of the service.

The registered manager told us they keep up to date with best practice in a number of ways. They attended training courses delivered by national good practice organisations to ensure they stayed up to date. They were also in touch with other local registered managers. The provider told us, in the PIR, that they worked in partnership with key organisations such as the safeguarding team, the local police force, local authorities and allied health professionals to ensure people got the support they needed. Records showed the provider did work with partner organisations; however, feedback we received from health and social care professionals was not wholly positive. Professionals told about difficulties in communication and in obtaining information.

Staff told us they were happy working at The Herons and were proud of their work. One member of staff told us, "I love it. My job means something. I would have my family here." Staff said they were given an opportunity to have a say in the running of the service in staff meetings. Records showed staff meetings took place regularly and were used to discuss areas such as, support for staff, training and the support each person received. Staff told us their ideas and suggestions were usually listened to and acted upon. One member of staff told us, "There has never been an occasion where we have brought something to the table and it has not happened." Staff said 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 registered manager.

People were able to provide feedback about the service in a number of ways. For example, each person was given the opportunity to have regular meetings with staff to enable them to share their views on different aspects of the service. Despite this, we found that most people had declined. We saw records of one meeting held with a person living at the home and saw they had been given the time and support to talk about things that mattered to them and the overall quality of the service.

We checked our records, which showed the provider, 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.

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 11 HSCA RA Regulations 2014 Need for consent People's rights under the MCA were not always respected. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from risks associated with the environment. Risks associated with people's care and support were not sufficiently assessed or mitigated. Regulation 12 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure the quality and safety of the service were not comprehensive or effective. Action was not taken in response to known issues. Regulation 17 (1) (2)