Optima Care Limited

Heron House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Heron House is a residential care home providing care to three people who needed support with their mental health or living with a learning disability at the time of our inspection. The service can support up to six people in two buildings.

People's experience of using this service and what we found
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People were at risk of harm from themselves and each other. When incidents occurred, there was a lack of oversight from the provider, which led to further incidents. The provider had not learnt from incidents. Staff did not have the training or the expertise to support people with their complex needs. There was a lack of guidance for staff to follow on how to support people to de-escalate situations. People were subject to abuse and had been physically harmed. The provider had failed to take action to review people's welfare and inform the relevant stakeholders.

Risks to people's health needs were poorly managed. Referrals to healthcare professionals had not been made when required. People told us they were unhappy living at the service. Staff who lacked knowledge about Mental Capacity had placed unnecessary restrictions on people and this had not been identified by the provider. The provider oversight was poor and ineffective. The provider failed to address concerns raised at our last inspection on 4 August 2020. At this inspection we found the service had further deteriorated. People had not been involved in making decisions about the service. When suggestions had been made by people, these had not been implemented by staff and management. There was a negative culture at the service, which was not person centred.

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 guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, Right care, Right culture. People had unnecessary restrictions placed on them, which triggered incidents of behaviour that could be challenging. Some parts of the service were restricted, for example the kitchen, a communal bathroom and the office. Staff did not have the competencies and skills to support people in a person-centred way, which had a negative impact on people. The provider had not taken action to address these shortfalls.

Right support:

• Model of care and setting did not maximise people's choice, control and Independence

Right care:
• Care was not person-centred and did not promote people's dignity, privacy and human Rights

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives

Following this inspection, we worked closely with the local authority (Kent County Council) to ensure people were safeguarded from ongoing harm. One person was supported to move out of Heron House, and alternative placements are being sought for all service users.

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 24 September 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about incidents between people, allegations of abuse and staff competencies. A decision was made for us to inspect and examine those risks.

We reviewed the information we held about the service. 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 changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heron House on our website at www.cqc.org.uk.

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 coronavirus and other infection outbreaks effectively.

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 continued breaches in relation to safe care and treatment, staffing, good governance, and new breaches in relation to safeguarding and notifications of other incidents at this inspection.

Following the inspection, we took immediate action to restrict admissions to Heron House. We took action against the provider and cancelled their registration for Heron House. Everyone who received a regulated activity has moved out of the service, and we have de-registered Heron House with the Care Quality Commission.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Heron House

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 two inspectors.

Service and service type
Heron House 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.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

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 five members of staff including a manager from another of the providers services, a consultant manager, a team leader, a support worker and an agency support worker. 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.

Inadequate

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 now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. 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.

● When serious incidents happened between people living at the service care plans and risk assessments were not updated. Some people could display behaviours that were challenging to others. There was no guidance for staff to follow to de-escalate situations.
● Some people were at risk of significant harm to themselves. There was no care plan or risk assessment to inform staff how to support them. Staff we spoke with lacked the knowledge and skill to support people during these incidents. One incident report stated that in response to a physical assault from a person, staff 'placed their hands on [the person's] wrists gently and asked them to stop.' No intervention strategies had been agreed for de-escalation, and the incident was not investigated by the provider, or shared with any stakeholders. The interim manager informed us no restraint was allowed to be used.
● Some people were at risk of ingesting liquids which could cause significant harm to them. These risks were known by staff but not managed. When such items were found in people's room no investigation was completed by the provider to review how these had been accessed, or plans put in place to mitigate this risk in the future.
● Risks to people's health were poorly managed. Some people had epilepsy; there was no care plan, risk assessment or information in their file to inform staff on action to take should the person have a seizure. Some people were at risk of constipation; there was no care plan or risk assessment in place to inform staff on actions to take should the person become unwell. Bowel charts were completed daily by staff but were not dated making it difficult to establish when the last bowel movement was. This placed people at significant risk. Some people needed support with their weight management. The GP had requested a person was weighed twice a week to review any changes to their weight. This had not been completed.
● Incident management and oversight was poor and ineffective. People were harmed as action had not been taken to address or mitigate against known risks. For example, serious physical incidents between people and staff had occurred in December 2020 and then again in January 2021. Incident reports had not been reviewed by the provider; incident de-briefs did not happen. The provider had not learnt from incidents to prevent further incidents occurring.

● Risks to the environment had not been assessed or mitigated. Fire drills had not been completed in excess of 12 months. Weekly fire checks were not being completed regularly. Staff meeting notes from January 2021 stated that a staff member had been told that 'due to behaviour [of people living at the service] fire drills are not to happen.' No follow up or investigation was completed into this, and a fire drill had not occurred when we inspected.

Preventing and controlling infection
● Only one staff member had completed training on 'Infection prevention and control including personal protective equipment (PPE)'. We observed one staff member not wearing all of the appropriate PPE when they were supporting a person.
● The provider was unable to assure themselves that agency staff did not move between different services in line with government guidance.
● Windows could not be opened to increase ventilation in the service.
● The providers audit of infection control was carried out on 3 August 2020.

The registered person failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not safeguarded from the risk of abuse, and had been subject to abuse. When people had been physically harmed by other people living at the service, no welfare checks were completed on them. Staff documented that one person was seen leaving another person's room. Despite the known risks between the two people, there was no investigation as to why the person was in the other persons room. There was no action taken to prevent further incidents. Some people were at higher risk of abuse as they could not verbalise concerns and relied on staff for this.
● One person had bruising noted on a body map. The investigation by the previous manager stated the person bumped into things when they walked. Staff told us this was not the case. No further investigation had been completed.
● One person raised concerns they were sad and uncomfortable in their own home. These concerns were not reported, or action taken to address them. One person raised concerns about feeling bullied by staff, no further action was taken to address this concern.
● People had unnecessary restrictions placed on them. For example, the kitchen, office and a communal bathroom had locks, so people had to ask staff to access these areas. When we asked staff why these restrictions were in place one told us it was from previous people who lived the service, and the other told us they did not know why there were restrictions.
● There was an incident on 15 January 2021, where the police were called about an alleged assault at the service. We asked staff and the manager from another of the providers service for more information about this incident, and they were not able to give us any information. This incident was not reported to CQC or the local authority safeguarding team.
● The provider failed to ensure all incidents had been reported to the local authority safeguarding team, or to the Care Quality Commission (CQC).

The failure to protect people from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staffing and recruitment

At our last inspection the provider had failed to deploy enough trained and competent staff. This was a breach of Regulation 18 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 18.

● Staff lacked knowledge and training on how to support people with behaviours that could be challenging, and how to support people with complex health needs. Staff did not recognise when behaviours escalated or had the skills to de-escalate.
● At our last inspection we identified staff did not have training in supporting people with mental health needs. At this inspection, nearly half the staff did not have training in mental health. Nearly half the staff team had not had training in Self Injurious Behaviour including Ligature Knife Training. Not all staff had been trained in; positive behaviour support (PBS), supporting people with a learning disability, Makaton or choking risks.
● We observed one staff member inappropriately supporting someone to stand. This was not challenged by the team leader.
● Staff competencies and supervisions were not regularly reviewed. This impacted on people, for example staff lacked knowledge around mental capacity, and therefore people had unnecessary restrictions in place which caused them distress. A staff member told us, "I think the gate in the kitchen was for [person who used to live at the service] the gate was to stop them, I don't know why it is still locked now, I can't answer that."
● The provider had not completed the necessary checks to ensure agency staff had the skills and competencies to support people. No competency checks had been completed on agency staff. Agency worker placement checklists were poor and were not in place for agency staff currently supporting people.
● There was a high volume of agency staff used to support people. The lack of guidance and documentation on how to support people with risks placed people at significant risk of harm.

The failure to deploy enough trained and competent staff is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● When new staff started working at the service, the relevant checks were not completed to make sure people were of good character to work with vulnerable people. Gaps in work history had not been explored by the provider. References were not verified or on letter headed paper and one reference was from an employee of Optima and known only to the staff member through another individual.

The provider had failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Using medicines safely
● The provider was not able to evidence that all staff administering medicines had completed competency checks.
● People had not been supported to become more independent. Self-administration assessments had not been completed to support people to become more independent in taking their medicines.
● Medicine administration records (MAR) were accurate and complete.
● Temperature checks had been completed to ensure medicines were stored at the correct temperature.

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 now 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.

Continuous learning and improving care

At our last inspection the provider had failed to engage and involve relevant persons and to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service. This was continued breach of Regulation 17 of the Health & 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.

● Following our inspection on 4 August 2020, the provider wrote to us with an action plan detailing how they planned to improve and meet the four breaches of regulation identified. The action plan was ineffective and had not addressed the concerns we raised during our inspection on 4 August 2020.
● The action plan submitted to us by the provider was inaccurate. For example, it stated that staff meetings would occur regularly. However, since the last inspection there had only been one staff meeting.
● On 26 January 2021 an audit was completed by the regulatory compliance manager. This was ineffective. For example, one person's file was reviewed, although the audit had identified risk assessments and other important information was missing to support the person to be protected from the risk of abuse no action was taken to improve this.
● Concerns identified as high risk were not responded to with urgency. A service improvement plan (SIP) was implemented as a result of the audit completed by the regulatory compliance officer on 26 January 2021. This was ineffective in improving the service; there was no responsible person assigned to complete the improvements. Actions identified as high priority, such as fire risks had not been addressed. Window restrictors not being in place had a completion date of 1 April 2021, people continued to be at risk.
● Monthly and weekly medicine audits had not been completed consistently. When a medicine audit was completed on 4 June 2020 there was no evidence that all actions had been completed, and there had been no follow up.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
● There was a closed culture at the service. A closed culture means a poor culture that can lead to harm, which can include human rights breaches such as abuse. Staff were reluctant to share information with us,

for instance when we asked staff about an incident that had occurred, they were not forthcoming with details about the incident. Staff told us, and we could evidence that information had been removed from the service; multiple pages had been removed from the communication book with no explanation. We asked the manager from another of the providers service, and the team leader why there was information removed, and they were unable to explain.

● People's human rights were infringed because they had restrictions placed on them. For example, people were told they could not have fizzy drinks, but staff told us they had capacity to make decisions. People were not given privacy to have conversations with their relatives.

● People were not spoken to in a respectful, dignified way. For example, following incidents people were told to go to their bedrooms.

● The duty of candour requires providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. The provider was not always open and honest when things went wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People were not involved in the service. When their opinion was sought, the provider failed to ensure actions were taken. For example, staff told us following an incident a person gave a previous manager a list of actions they wanted to change at the service. These were not implemented, and staff did not know where the list was.

● Not everyone at the service was able to vocalise their choices. There was limited information in pictorial format for this person, and no consideration had been given about how to support them making simple choices such as food menus.

● The provider had not sought support from healthcare professionals when people needed specialist support. For example, referrals had not been made to the speech and language team (SaLT) and when people's mental health deteriorated support was not sought from mental health professionals. This placed people at significant risk of harm.

The failure engage and involve relevant persons and to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service is a continued breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● At the time of our inspection, there was not a registered manager in post. This is a condition of the provider's registration with the CQC. The registered manager had left the service in June 2018. Since then the service had been managed by nine different managers.

● Regulatory requirements were not met as the provider failed to notify the CQC and the local authority safeguarding team when required.

● The provider failed to ensure that legislation was complied with; people had been unlawfully restricted.

● The provider failed to ensure there was adequate risk assessments and guidance in place for staff to follow, placing people at risk of harm.

The failure to notify the CQC of safeguarding incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The failure to notify the CQC of safeguarding incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The enforcement action we took:

NoP to remove location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

NoP to remove location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

NoP to remove location.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure engage and involve relevant persons and to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service is a continued breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

NoP to remove location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014

The enforcement action we took:

NoP to remove location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to deploy enough trained and competent staff is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

NoP to remove location.