Bhandal Care Group (1ST Care UK) Ltd

Heatherlea House Residential Care Home

Inspection report

109 Tor O Moor Road
Woodhall Spa
Lincolnshire
LN10 6SD

Tel: 01526353394

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Heatherlea House Residential Care Home provides accommodation and care for up to 17 older people in one adapted building. On the day of our inspection 16 people were living at the service

People's experience of using this service and what we found
Risks to people health, safety and welfare had not always been identified or assessed. When risks had been identified, actions had not always been taken to mitigate those risks. In addition, lessons had not been learned and appropriate actions taken following serious incidents.

Medicines were not always managed in a safe way. Recruitment procedures were not always robustly implemented.

Quality assurance systems did not always identify concerns with people's care or the environment. In addition, they did not include a robust system for recording the actions required and taken to resolve issues or minimise risk.

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

People felt safe and well cared for and staff felt supported in their work.

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

Rating at last inspection
The last rating for this service was good (published 9 August 2018).

Why we inspected
The inspection was prompted in part by notification of an incident in which a person was seriously injured and subsequently died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. 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 the assessment and management of falls risks. This inspection examined those risks.

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

We have found evidence that the provider needs to make improvements. Please see the safe and well-led

sections of this full report.

For those key questions not inspected, we used the ratings awarded at the last comprehensive inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

Enforcement
We have identified breaches in relation to risk management, medicines management and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Heatherlea House Residential Care Home

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 Health and Social Care Act 2008.

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 2 inspectors.

Service and service type
Healtherlea House Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Healtherlea House Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

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 who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 9 people who used the service about their experience of the care provided and observed the care people received. We spoke with 5 members of staff including the registered manager, a senior carer, 2 care workers and the registered provider.

We reviewed a range of records. This included 3 people's care records and multiple medication records. We looked at 3 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.

Following the site visit we continued to seek clarification from the provider and registered manager to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Risks were not always safely managed,
• A staircase risk assessment carried out in 2019 identified actions required to reduce the risk of people falling on the stairs. However, the identified actions had not been carried out at the time of this inspection despite the risk assessment having been reviewed at regular intervals.
• Both staircases in the home were fully accessible to people; one also had a chair lift fitted. This increased the risk of injury if people used the stairs or stairlift unsupervised.
• Personal risk assessments and management plans were of variable quality. Some risk management plans accurately reflected the care we saw, and what people told us about. However, other risk management plans contained only basic information. For example, one person who was cared for in bed had been assessed as being at risk of choking on food and at risk of poor nutritional intake. The management plan indicated the person needed food to be of soft consistency but did not provide detail of how the person should be positioned in order to eat safely or how staff should record food and fluid intake.
• The use of bedrail safety covers had been assessed for people who needed them. However, we saw covers were not always in place, or did not fully cover bedrails in line with assessments. This increased the risk of people being injured, for example, trapping limbs between uncovered rails.
• Assessments had not been completed in regard to risks posed by furniture. We saw 9 bedrooms where wardrobes had not been secured to walls. This increased the risk of people being injured if wardrobes toppled over.
• Following a serious incident there was no evidence to show the registered manager and provider had learned lessons and taken action to reduce the risk of people falling and being injured on stairs. Other records such as minutes of staff meetings and complaint responses indicated lessons were learned from some incidents and events that had taken place.

Using medicines safely
• Medicines were not always managed safely.
• Some medicines are required to have extra storage and recording controls in place. Although these medicines were stored correctly, records were inaccurate. This meant it was not possible to ascertain which medicines were available to people when needed.
• Instructions for medicines taken as and when required, known as PRN medicines, were not always in place. This meant staff did not have clear guidance as to when and how to administer these medicines. This placed people at risk of not receiving their medicines as prescribed.

The provider failed to ensure that care and treatment was appropriately assessed and provided in a safe

way. This was a breach of the regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the registered provider informed us they had taken action to secure stairwells and bedroom furniture; bedrail safety covers were in place where required and risk assessments were being reviewed and updated.

Staffing and recruitment
• Although we did not find any impact for people, 3 staff recruitment files did not contain references from either previous employers or in regard to their character. Each file contained a statement indicating risk assessments had been completed so new staff could start work prior to return of the requested references. However, risk assessments could not be located by the registered manager.
• Recruitment records showed other information had been collected in line with the provider's policy. For example, proof of identity and Disclosure and Barring Service (DBS) checks. These checks provide information including details about convictions and cautions held on the Police National Computer.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe living at Heatherlea House. One person said, "I'm definitely safe here; they really look after me."
• Staff received training about how to keep people safe. They were able to identify signs of abuse and knew how to report any concerns in this regard.
• The registered manager understood their responsibility to raise safeguarding concerns with the local authority and to notify CQC of any instances of abuse.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

• We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Preventing and controlling infection
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was supporting people living at the service to minimise the spread of infection.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was responding effectively to risks and signs of infection.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.

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

Visiting in care homes
• The provider followed current government guidance on care home visiting.

Requires Improvement

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 our last inspection we rated this key question Good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• Although there were currently enough staff deployed to meet people's needs, the registered manager told us this had not been the case until recently. The registered manager said previous shortages of staff had meant she and the deputy manager had been completing care which had impacted on the amount of time they had to carry out management functions.

• Systems for monitoring the quality of the service were not always effective. Audits had failed to identify issues we found at this inspection regarding bedrail safety, management of medicines and the safety of furniture. This meant people were not always protected from the risks of unsafe care.
• In addition, action plans had not been put in place to address issues that had been identified by audits. An example of this was related to fluctuating hot water temperatures. Although the registered manager told us about the actions they had taken there was no record of this or the timescales in which they had been completed.
• The provider's recruitment policy was not robust. It did not clearly identify actions to be taken if the required recruitment documentation was not provided by prospective staff members. This meant there was a risk of employing staff who may not be suitable to work with people who were unable to keep themselves safe.
• There was no system in place to ensure care workers who were promoted to senior caring roles had additional training. This meant they were not always fully aware of the expectations and responsibilities of the role and may not have the skills needed to carry out their role effectively.

The provider failed to implement robust systems and processes to ensure good governance. This was a breach of the regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered manager understood and complied with the regulatory requirement to notify us about events which happened in the home.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People told us there was a supportive and open atmosphere in the home. One person said, "You only have

to mention something you're not happy with and the staff sort it out." Another person said, "They know how I like things done and they always do it right."
• Staff provided person-centred care for people. For example, we saw staff speaking with people about how they wanted to be supported with moving around. A staff member spoke about the importance of personalised care as 'people liked different approaches on different days'.
• Staff told us they felt supported in their work and were confident to raise issues or ideas for improvement.

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; Working in partnership with others
• The manager showed an understanding of the duty of candour and we saw evidence of families being contacted regarding documented concerns or incidents.
• The registered manager told us they worked closely with the local authority and other healthcare professionals. We saw evidence of the registered manager taking part in regular multi-agency meetings with healthcare professionals as a way to improve people's care and support.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that care and treatment was provided in a safe way and assessed appropriately. This was a breach of the regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to implement robust systems and processes to ensure good governance. This was a breach of the regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.