

# Yorkshire Regency Healthcare Limited

# The Heathers

## Inspection report

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12 September 2022  
21 September 2022

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service effective?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

### About the service

The Heathers is a specialist residential service providing personal care to a maximum of 34 people, inclusive of respite service. The service provides support to people with alcohol and/or substance misuse. At the time of our inspection there were 33 people using the service. The Heathers is an adapted building which includes double bedrooms for people and ensuite facilities.

### People's experience of using this service and what we found

We have made a recommendation about the safe storage of some medicines. Medicines were not managed safely. People were not always safe. People were at risk of harm as the provider had not identified, assessed or mitigated risks. This included risks related to people's health and care needs as well as environmental risks. People told us "I don't feel safe here, my belongings are stolen, and I get threatened by others but nothing is done about it". Near misses were not always recorded. The environment was tired, not homely and not well maintained. The quality of basic essentials such as bedding and soft furnishings were poor. There was a lack of care and attention visible throughout the whole home. For example, dining chairs in the conservatory area were heavily stained with food debris.

Recruitment processes were in place to check staff were safe and suitable to work in the service before they were employed. Staffing levels were sufficient through the week days but staff told us they reduced on a weekend making it difficult to complete all tasks.

People's care records were not all person centred and some did not fully reflect their needs. Preadmissions to the service were not completed safely with assessments and documentation for care plans not completed efficiently. There was little to occupy and interest people. People did not receive sufficient professional support to manage their drug or alcohol dependence and had no plans in place to reduce this reliance, so they were able to live independently.

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. There were no mental capacity assessments or best interest decisions for people who were in receipt of restrictive practices.

There was a lack of effective leadership and an ineffective governance structure which meant the service was not appropriately monitored at manager or provider level.

People's nutritional needs were met, and people were happy with the choice of food. Staff training was up to date and most staff were receiving supervisions. Infection control measures were followed, staff were observed to be wearing masks correctly on both inspection dates.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection

The last rating for this service was good (published 9 March 2018).

### Why we inspected

This inspection was prompted by a review of the information we held about this service. As a result, we undertook a focused inspection to review the key questions safe, effective and well led. For those key questions not inspected, we used the ratings awarded at the last 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.

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 the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Heathers on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

### Enforcement and Recommendations

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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, medicines management, premises and equipment, consent to care and good governance at this inspection.

We have made a recommendation about the safe storage of some medicines.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

### 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?

The service was not always safe.  
Details are in our safe findings below.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.  
Details are in our effective findings below

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led.  
Details are in our well-led findings below.

**Requires Improvement** ●

# The Heathers

## 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 first day of inspection was carried out by three inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of inspection was carried out by two inspectors.

#### Service and service type

The Heathers 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. The Heathers 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. Inspection activity started on 12 September 2022 and ended on 28

September 2022. We visited the location on 12 September 2022 and 21 September 2022.

#### What we did before the inspection

We used information gathered as part of monitoring activity that took place on 20 June 2022 to help plan the inspection and inform our judgements. We sought feedback from the local authority and professionals who work with the service. We also used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

#### During the inspection

We spoke with 14 people who use the service and two relatives about the experience of the care provided. We looked around the building and observed people being supported in communal areas. We spoke with seven staff including the registered manager, team leaders, seniors and care staff. We spoke with one health care professional.

We reviewed a range of records. This included five peoples care records, sampling specific areas of another five peoples care records and multiple medication records. We looked at two staff files in relation to recruitment and a variety of records relating to the management of the service, including audits and policies.



# 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 people were safe and protected from avoidable harm.

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

- Risk assessments were not always in place to manage risks to people from choking. One person had four documented incidents of choking on a range of foods, their nutritional care plan did not reference the choking risk and did not provide any guidance to staff on how to support the person at mealtimes. There was no risk assessment in place for this choking risk. The person regularly ate food which they were known to choke on in their room with no supervision from staff.
- We reviewed incident records which showed some people regularly abscond from the service. One person was assessed as unsafe to go out of the service alone and had a deprivation of liberty safeguard in place (DOLS). Despite the risks to the person if they do abscond there was no guidance for staff in the care plan on how to engage with this person and support them to go out accompanied. We saw no evidence the provider had explored any way of supporting the person to reduce the occurrences of absconding.
- Smoking risk assessments were reviewed. We found these were identical for two people and lacked any person-centred information. One person's smoking risk assessment stated they should have 30-minute bedroom checks to ensure they were not smoking. We saw no evidence these checks were being completed.
- Accident and incident reports were documented clearly however, there was a clear lack of action taken to mitigate future occurrences.
- Lessons were not learnt. For example, in August 2022 one person used a broken wheelchair in the back garden to assist with climbing over the wall and absconding. This wheelchair was still in the back garden on both onsite inspection dates.

We found systems were not robust enough to demonstrate the risks to people's health and safety were effectively managed. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Health and safety audits were completed by team leaders and identified multiple environmental issues. Some of these were not rectified appropriately, and the majority of issues were not fixed. The audits failed to identify any plan of action resulting in continued risk to people. For example, one person's window restrictor broke in June 2022. A remedial fix was completed by maintenance, but this was not checked by the provider. During onsite inspection days we saw the chain restrictor was not secure and could be unscrewed by hand. This person was on the second floor of the service and had a risk assessment in place which stated the person was at risk of jumping out of the window.
- On both days of inspection, we observed the environment to be run down, not well maintained and overall, not clean. Sofas were worn, carpets and flooring were stained, bedding was thin, walls and décor were dirty and damaged.

- People's belongings were not kept safe. People told us how their personal items had been stolen by others. One person said, "I found someone in my room trying to steal my belongings I have to keep everything on me at all times". People did not have access to keys to securely lock valuables away in drawers in their rooms. Many people also did not have keys to their own bedrooms doors and could not lock these when unoccupied.

We found the premises and equipment were not clean, secure, suitable for purpose, or properly maintained. This placed people at risk of harm. This was a breach of regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation.

#### Using medicines safely

- Medicines were not managed safely.
- Medicines reconciliation (checking medicines on admission) was not safely carried out. One person had not received a critical medicine resulting in harm.
- There were no dose directions on how to administer insulin on the medicine's administration records for one person.
- Handwritten medicine administration records were not fully completed for some people. They did not contain people's allergy status and were not signed by two members of staff as per medicines policy and national guidelines. This meant there was a risk medicines might not be given safely.

We found systems were not robust enough to demonstrate medicines were managed safely. This placed people at risk of harm. This was a further breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Medicines audits were completed, although did not recognise fridge temperatures had been out of range since at least January 2022.

A recommendation was made on the day of the inspection to include the range of temperatures within the medicines audit. A new fridge was ordered on the day of inspection to replace the fridge currently in use.

- Medicines including controlled drugs (medicines liable for misuse) were stored safely.
- Body maps for applying creams were in place, so staff knew where to apply the cream.

#### Systems and processes to safeguard people from the risk of abuse

- The service did not have an effective system in place to record the number of cigarettes and alcohol given daily to people. We found multiple examples of stocks not matching the balance on the records. There was no action taken when discrepancies were found and no system for auditing or escalating the concern. One person had over 20 cigarettes missing from their stock in one day, with no evidence of where they had gone. This exposed people to the risk of theft/harm.
- People told us they had reported instances of other people stealing their belongings and incidents of actual bodily harm from other people in the service. The provider kept a 'grumbles book' but this failed to detail any action taken in response to the concerns raised. This was raised with the registered manager at the end of the inspection days and on a separate occasion after the onsite inspection dates. The registered manager was responsive and has implemented new system and procedures to reduce potential risks to people.

#### Preventing and controlling infection

- We were not assured that the provider was promoting safety through the layout and hygiene practices of



the premises. Multiple areas of the service were not clean and worn furniture made cleaning and maintaining infection prevention and control measures difficult.

- We were not assured that the provider was supporting people living at the service to minimise the spread of infection. We observed people not maintaining social distancing and people were mixing with each other in all areas of the service.
- We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. People in shared rooms had no way of appropriately and safely isolating if they were COVID positive and zoning was not used in the service.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider's infection prevention and control policy was up to date

#### Visiting in care homes

- The provider was supporting relatives and friends to visit people safely. We saw relatives and friends were welcomed and could spend time with their relative where they preferred. The appropriate safeguards were in place to protect people.

#### Staffing and recruitment

- Staffing levels were reviewed regularly and through the week the service had enough staff on each shift. On a weekend the service ran on the same amount of care staff however there were only one team leader, no manager, no cook and no domestic. This stretched the care resources. Staff told us, "on a weekend one care staff member could be left on their own to supervise people which is dangerous. It would mean if there was an incident of challenging behaviour, we wouldn't have anyone around to help as staff have to cook".
- People and relatives felt there was enough staff if they needed any support, they could get some.
- Safe recruitment practices were followed. New staff had Disclosure and Barring Service (DBS) checks prior to employment. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safe recruitment decisions.

# Is the service effective?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The service was not working within the principles of the MCA.
- Mental capacity assessments and best interest decisions (BID) were not in place for anyone in the service.

The provider had failed to ensure people's care and support was delivered in line with the MCA. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A DOLS tracker was in place which showed when applications had been made and granted and whether the authorisations had any conditions.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

- People's needs were not properly assessed before they moved into the home. A pre-admission assessment had not been completed for the most recent respite service admission. As a result, a vital medication was missed for two weeks. This resulted in harm to the person and hospital admission.
- Another person's care plan had not been completed, despite there being 19 days since their admission. This person had short term memory loss. The care plan missed important information for staff and the person, such as induction and orientation around the service, consent to cares, screening tools and some risk assessments.
- The building had not been adapted to meet people's needs and multiple parts of the environment required redecorating and refreshing.

Staff support: induction, training, skills and experience

- Records showed new staff completed an induction
- Training matrix showed most staff were up to date with all their training. However, staff told us "The training is basic and online. We are a specialist service and we need more in-depth training especially around specific subjects such as alcohol and substance misuse. We don't have enough knowledge of this".
- Records showed staff had received supervisions and appraisals in the last six months and felt they could go to the manager with any concerns and for support

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

- People's nutritional needs were met. Where people had lost weight, staff were involved in making up nutritional shakes to support with weight gain. The cook was aware of who was at risk of weight loss.
- People told us they were happy with the food provided. One person said "The food is good, can't fault it".
- We observed mealtimes on both days of inspection. Mealtimes were relaxed with condiments on the table.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- The service did not utilise support from external agencies to support people with managing or recovering from their drug and alcohol misuse. Many people told us they had received no help, support or guidance with managing their drinking, health or wellbeing. Care records did not show involvement from specialist services or any support being provided to people for the management of their alcohol use or wellbeing.
- People's care records confirmed the involvement of other professionals in providing care such as the GP, chiropodists, speech and language therapists, opticians and dentists.
- The service also used a tele-meds system and has regular weekly contact with the GP.

# 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; 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;

Continuous learning and improving care

- Shortfalls were identified at this inspection some of which had been identified by the providers own audit system. There were breaches in relation to safe care and treatment, medicine management, consent and premises and environment. These issues had not been addressed through the provider's own governance systems.
- Following the first day of our inspection we informed the provider of our concerns and requested a response detailing the action they would take to ensure people were safe. We made referrals to the local authority safeguarding team. The registered manager sent assurances. When we returned on the second day some issues had been addressed but further issues were identified.
- There was a lack of effective management and leadership.
- Quality audits were not effective in identifying or securing improvements. For example, monitoring and analysis of accidents and incidents was ineffective. The audits were completed by team leaders but failed to identify trends or patterns. There was no evidence the registered manager reviewed or had oversight of these audits, and we found no actions were taken to mitigate future risks. Maintenance issues were not always identified. However, where issues were identified these were not addressed. This included broken headboards, curtain partitions not being in place in double rooms, window restrictors not suitable and intumescent strips missing on fire doors.
- Provider oversight and monitoring was ineffective in identifying and managing organisational risk. Audits completed failed to identify or resolve the issues we found at the inspection.
- People and their representatives had not always been involved in their care planning. One person told us "Staff haven't said a word about my care plan or what will happen to me, or how long I might be at the home". A relative told us they were "unclear on what is going to happen with [name] going forward, we don't know what [name] care plan is or entails. We have not been involved in this".

People were placed at the risk of harm through the lack of effective governance systems. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager had complied with the requirement to notify CQC of various incidents, so we could monitor events happening in the service.

- We saw evidence there was regular service user meetings to gain feedback, with recent ones detailing discussions around the no smoking policy, the home, mealtimes and activities. Staff meetings were also evidenced and occurring regular.
- Staff surveys had been completed and made many suggestions about how the service could be improved such as maintenance works and refurbishment and more activities 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;

- The manager understood the requirements of the regulations to make notifications and to comply with duty of candour responsibilities when things had gone wrong.

Working in partnership with others

- We spoke with a visiting health care professional and they spoke positively about partnership working. They visited the home regularly and had positive feedback for the team leaders. They said, "They are really good and always know when it is the right time to contact us".

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  Regulation 11: need for consent. Consent was not readily recorded with a lack of MCA/BID for people with restrictions and on DOLS.

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 12 HSCA RA Regulations 2014 Safe care and treatment  Reg 12 Safe care and treatment (1) (2) (a) (b) (d) (e) (f) (g) (h). The provider failed to assess, monitor and mitigate risks to service users.

### The enforcement action we took:

Warning Notice served to RM and RP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment  Regulation 15: premises and equipment. The provider failed to ensure the premises and equipment were secure, clean, suitable for their purpose and maintained appropriately.

### The enforcement action we took:

Warning notice served to RM and RP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Reg 17: Good governance. The provider did not have safe systems and processes in place, failed to monitor the service, and therefore did not have effective oversight to drive performance and compliance.

### The enforcement action we took:

Warning Notice served to RM and RP