Optima Care Limited

Heron House

Inspection report

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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
Heron House is a residential care home providing personal care to three people who need support with their mental health or living with a learning disability at the time of the inspection. The service can support up to five people.

People's experience of using this service and what we found
People, relatives and staff informed us they had been very unsettled by the lack of continuity with the management and staffing at the service. There had several managers at the service within the past twelve months which people told us was 'unsettling'.

Risks to people were known, however staff did not have a good understanding of how to manage these risks following an incident, placing the person at potential further harm. Accident and incident records were not reviewed by the provider to make and embed improvements. The provider did not ensure there were sufficient suitably trained staff.

There was a new manager in post at the time of our inspection, who had been introduced to people and their relatives. Staff told us they saw some improvements. However, the provider had not acted quickly enough to address long standing short falls. This included oversight of accidents and incidents and training of staff to support people.

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 Good (published 15 March 2018).

Why we inspected
We received concerns in relation to the management of medicines, staffing and risks to people. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. 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 Good to Requires Improvement. 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.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

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 as part of our Thematic Review of infection control and prevention in care homes.

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
We gave a short period notice of the inspection to check if the service had an active cases of COVID 19.

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. We used all of this information to plan our inspection.

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.

During the inspection
We spoke with one person who used the service about their experience of the care provided. We spoke with six members of staff including the provider, manager, operations manager and care workers.

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. We spoke with three care staff and two relatives.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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

- Although risks to people had been identified and detailed risk assessments were in place to advise staff how to support people, we found this was not always the case.
- On four occasions from December 2019 to February 2020 one person came to harm. The person's risk assessment detailed they should have 30 minute checks to 'reduce the likelihood of risks occurring'.
- We found that staff did not follow these steps on the risk assessments. Staff were unaware of the frequency checks should take place, and daily notes evidenced 30 minute checks were not completed on the day of incidents, or the days that followed, placing the person at further risk.
- Accident and incident forms were completed when incidents took place, however there was no details of management review or actions taken to reduce the likelihood of the incident re-occurring.
- The manager and provider had not analysed accidents and incidents. For example, following a person coming to harm on four occasions, there was no analysis of the potential triggers, trends, and action taken to reduce the likelihood of the incident reoccurring.
- The provider was not implementing and embedding improvements and learning from incidents that occurred.

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

- Safety checks on the environment had been completed, these included testing the water for legionella.

Staffing and recruitment

- There were insufficient staff deployed with the training to meet people's needs. This impacted on the support people received to meet their assessed needs. People's needs regarding their mental health were not always recognised or appropriately responded to.
- Provider records evidenced none of the staff had completed training in supporting people with mental health needs. This had been identified by the provider, and staff had been booked to complete training in mental health in the weeks following our inspection. We will check this has been implemented on our next inspection.
- We checked staff recruitment files and found the provider had completed the necessary pre- recruitment checks, including reviewing people's work history and completing a Disclosure and Baring Service (DBS) checks to ensure that they were suitable to work at the home.

The failure deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People's medicines were managed safely by staff who had been trained and assessed to be competent in medicines administration.

● Medicines administration records (MAR) were accurate and complete, and where required had the signature of two staff members.

● Staff identified when one person was having 'as and when' medicines regularly, and contacted the GP for a review. The person was then prescribed the medicine, and was no longer 'as and when' needed.

Preventing and controlling infection

● We observed the service to be clean and well maintained.

● The provider had implemented procedures to keep people safe from the risk of Covid-19. For example, people's temperatures were checked on arrival before entering the service.

● Staff were observed to be wearing appropriate PPE (personal protective equipment) and the provider had ensured there were sufficient supplies of PPE.

Systems and processes to safeguard people from the risk of abuse

● People and their relatives told us they felt safe living at the service.

● Staff had received safeguarding training, and staff we spoke with told us they were confident to raise concerns to the provider, and understood how to safeguard people from potential abuse.

● The provider had reported any safeguarding concerns to the local safeguarding authority as appropriate.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People, relatives and staff told us there had been a negative culture at the service.
- People, relatives and staff told us it had been 'difficult' and 'stressful' at the service with the many changes in staffing. A relative told us, "We were not introduced to any of the managers except the most recent. [My loved one] feels they are not respected enough to tell them about changes." A staff member told us, "It has been so stressful having so many managers."
- People, staff and relatives told us they were concerned about the lack of leadership and the volume of staff who had left. A relative told us, "The biggest worry we have has been the turnover of staff, including the manager. It has really affected morale."
- One person told us they felt patronised by staff and management, for example that staff spoke in loud voices to them.
- People were not always treated in a person-centred way. For example, when questionnaires were sent out to people, they were all sent in an 'easy read' format regardless if the person needed that version.

Continuous learning and improving care

- The provider had a monthly report completed to review the quality of the service, with dates items needed action by and rated in priority order.
- Although the provider had identified some shortfalls identified in this inspection, action to address the issues had not been timely. For example, staff training had been organised for August 2020, however staff had been supporting people with mental health needs for years.
- Care plans were in the process of being reviewed, but the provider and staff had not identified key information missing from files. For example, one person's file noted they had seizures, but there was no risk assessment or further information to support staff in the file. Following the inspection this information was forwarded to us.
- It had been identified that accident and incident analysis overview was not in place at the service. Although the provider was able to evidence what they planned to implement there had been a lack of oversight in this area.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People, relatives and staff told us there had been a lack of engagement from the provider.
● People and their relatives did not feel consulted about changes in the service, for example when managers left and a new one was bought in.
● The new manager had met with people, and their relatives where appropriate to discuss introduce themselves and request feedback for the service.
● Staff meetings had been held on an ad hoc basis. The manager had held a staff meeting to introduce themselves and discuss items such as training and remind staff of policies and protocols within the service.

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
● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found that the provider had displayed their rating on the provider's website but had failed to display the rating in the entrance of the service.

The failure to display the service rating is a breach of Regulation 20A of the Health and Social Care Act 2008 (regulated Activities) 2014.

● 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 staff and relatives told us the service had been managed by six different managers. The most recent manager had been appointed and had applied to be registered with the CQC.

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 provider understood their responsibilities to be open and transparent with people and their representatives when things go wrong.
● The provider told us there had been no incidents meeting the threshold of duty of candour.

Working in partnership with others
● Staff had been working with healthcare professionals including the community mental health team, physiotherapists and social workers.

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 assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed 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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider failed to display the service rating.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff.