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Heathside Retirement Home

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

Heathside Retirement Home is a residential care home providing personal care to 30 people aged 65 and over at the time of the inspection. The service can support up to 30 people.

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

At this inspection we only looked at the key questions safe and well led.

The quality assurance system was not robust. The registered manager was not pro-active in communicating with senior staff members about the audits they had completed.

Staff had not always received the necessary support and training to be able to effectively write risk assessments and care plans. One person's care plan had not been reviewed in a timely manner after they had moved to the service, resulting in the care plan not being reflective of their needs.

Accidents and incidents were recorded and reviewed by the registered manager. However, the staff had not recognised the seriousness of one incident, which meant it was not correctly recorded. The registered manager, partner and training and development manager said they were not aware of a change in one person's support needs, which meant risks for this person had not been adequately assessed and managed.

People received their medicines as prescribed. We have made a recommendation about reviewing how the medicines round is managed.

Staff felt able to speak to the registered manager and regular staff meetings and supervision meetings were held.

People and relatives said they felt safe living at Heathside.

There were sufficient staff on duty to meet people's identified needs. Infection prevention and control measures had been reviewed in light of the Covid-19 pandemic.

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 August 2018).

Why we inspected

We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about the risk management and

quality assurance systems in place at the service. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the governance and quality assurance at the service, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

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 improvements. 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 Heathside Retirement Home on our website at www.cqc.org.uk.

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 a breach in relation to the quality assurance and oversight of the service 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 and will meet with the provider to discuss 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?

The service was not always safe.

Details are in our safe 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 ●

Heathside Retirement 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. This was a focused inspection which included the key questions of safe and well-led.

Inspection team

The inspection was carried out by one inspector.

Service and service type

Heathside Retirement Home 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave the service 48 hours' notice of the inspection. This was to the Covid-19 pandemic to ensure we had prior information to promote safety. We also asked for information to be sent to us electronically prior to the inspection visit. Inspection activity started on 20 July 2020 and finished on 10 August 2020. We visited Heathside on 22 July 2020.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority quality and safeguarding teams and professionals who work with the service. We

used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with eleven members of staff whilst at the home and afterwards by telephone. This included both partners, registered manager, training and development manager, assistant manager, senior care workers, care workers and housekeeper. We did not speak with any of the people living at the service during the inspection as local authority social workers had spoken with every person living at the home two weeks prior to our inspection and we used their feedback to inform our inspection.

We reviewed a range of records before, during and after our visit to the home. This included three 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 meeting minutes and call bell records. We spoke with three relatives of people living at Heathside to gather their feedback about the home.

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

- The risk assessments and care plan for the person involved in the incident that prompted this inspection was not reflective of their needs. Staff described the person as being able to independently mobilise, transfer and get dressed. However, the risk assessments and care plan stated they required staff support in all these areas.
- The risks associated with the person locking their bedroom door at night had not been recognised or assessed. Guidance was not in place for staff in this situation which resulted in night-time checks not always being completed. A policy has now been written to guide staff if people choose to lock their bedroom door.
- The care plans we reviewed reflected people's needs. Feedback from social workers was that other care plans they had reviewed did reflect people's needs and the support they required.
- A system was in place to record and review any accidents or incidents. However, we were aware of one incident where a service user went into another person's bedroom room, which had not been recorded correctly in the care records or an incident report written. Staff had not considered it as a serious matter. Consequently, the registered manager was not fully aware of this issue and the outcome, which was that the person started to lock their bedroom door.

The systems had not been robust enough to ensure incidents of concern were reported and the increased risks recognised and assessed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Staff received training and had competency checks for administering medicines.
- All staff we spoke with who administered medicines told us they signed the medicines administration records (MARs) after they had administered a person's medicines. The MARs we reviewed had all been correctly completed.
- The medicines trolley for people living on the first and second floors of the home was located on the first floor. However, at the times when the medicines rounds were completed most people were on the ground floor, in the lounge or dining room. Therefore the staff had to go up and down the stairs with each individual person's medicines.

We recommend the process for completing the medicines round are reviewed to reduce the time taken and the risk of dropping tablets or being interrupted in the middle of administering a person's medicine.

- The local Clinical Commissioning Group medicines optimisation team were due to support the home with

their medicines policy and organisation.

Staffing and recruitment

- There were sufficient staff on duty to meet people's needs. Staff worked with different colleagues on each shift. Some staff worked a combination of day and night shifts.
- Staff were safely recruited, with all pre-employment checks being completed before a new member of staff started work.

Systems and processes to safeguard people from the risk of abuse

- Relatives we spoke with felt their relative was safe living at Heathside. One said, "Yes she's safe, I can't speak highly enough about them." Feedback provided by the local authority social workers was that people had told them they liked living at Heathside.
- All staff had completed training in safeguarding vulnerable adults. Staff explained they would report any concerns they had to the management team; however, as above, not all information had been clearly communicated to the management team. The home had a safeguarding policy in place.

Preventing and controlling infection

- Infection prevention and control procedures had been increased during the Covid-19 pandemic. Handwashing facilities had been installed by the front doors so staff and any professional visitors were able to wash their hands immediately on entry to the building. Personal protective equipment was readily available for the staff team.
- Domestic staff were working additional hours to complete increased cleaning schedules, especially of touch points like light switches.
- At the time of our inspection there had not been any Covid-19 cases at Heathside.

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.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- A quality assurance system was in place; however this was not robust. The registered manager and registered partner did not have a full oversight of the service.
- The registered manager was not clear about the details of the audits. They did not pro-actively check that the audits had been completed and if any issues had been found. They assumed every audit was okay as no one had told them otherwise. A monthly managers meeting was held giving a brief overview of the service, but this did not identify the issues found at this inspection.
- A monthly care plan audit only reviewed one person's care plan per month, meaning it would take two and a half years to audit each person's care plan. A care plan written by a member of staff who was new to writing care plans, had not been checked or reviewed by the management team. It had also not been reviewed a month after they moved to the home, in line with the home's policy, or audited. It was not reflective of the person's support needs. The training and development manager completed the care plan audits but was not aware how frequently care plans should be reviewed. They also verbally asked the registered manager if accidents had been reviewed and did not satisfy themselves that this was the case.
- Daily records provided insufficient detail about the support provided or were not written at all. The night records were reviewed, but days records were not. There was no detail of any action taken when the records had not been completed or did not contain enough details.
- The management team did not carry out regular night visits at the home to have oversight that the night duties were being completed. The night staff were able to speak with the registered manager at the end of their shifts as the registered manager was part of the daily handovers.

The lack of a robust quality assurance system giving a clear oversight of the service was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Staff said the management team were visible and available for them to speak to. They said they would raise any changes in people's needs with the management team. However, the management team said they were not aware that one person had started to lock their bedroom door at night.
- Regular staff meetings were held. Staff and the management team said that staff raised any concerns or

ideas during these meetings. However, the minutes of the meetings and what we found did not reflect this. Staff also had regular supervision meetings with the training and development manager, during which they were able to discuss any concerns they had.

- All staff reported that there were no issues between the day and night staff and agreed tasks were completed by the night staff. This was helped by the fact that some staff worked both day and night shifts at the home.

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 registered manager notified the CQC and safeguarding teams of any accidents and incidents as appropriate.
- A complaints policy was in place, however, relatives told us they were able to speak directly with the registered manager or staff to resolve any issues without needing to use the formal complaints procedure.
- Following the incident that prompted this inspection, the partner for Heathside had completed an investigation and shared this with the relevant professionals.

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

- Relatives we spoke with said they had been involved in agreeing and reviewing their relatives care and support plans.
- Annual surveys were completed for staff, relatives and people living at the service. The results were collated, any themes identified and steps taken to address any issues raised. The staff survey results we saw from June 2020 were positive.
- The home worked with other professionals such as GP's and district nurses. Changes had been made during the Covid-19 pandemic, with more consultations taking place via video link to reduce the number of visitors to the home.

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 17 HSCA RA Regulations 2014 Good governance The quality assurance system was not robust; the registered manager did not have full oversight of the service.