Jeesal Residential Care Services Limited

Heathers

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
Heathers is a residential care home providing personal care to eight people with learning disabilities, autism and mental health conditions at the time of the inspection. The service can support up to nine people. The care home accommodates people in individual self-contained apartments with ensuite bathrooms, kitchen and living area. Two apartments are in the main 'farmhouse' and the remaining accommodation is around an adjacent courtyard. There is communal outdoor space and a communal activity room.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support. The service was in an isolated location at the end of a mile long un-made road. There was no nearby local community for people to engage with. People were supported on a one to one basis in their own self-contained apartments and little attempt was made to help them socialise with each other.

People's experience of using this service and what we found
At our last inspection we found evidence of a closed culture where staff failed to report concerns and escalate them to managers. There was evidence of incidents of abuse by staff. At this inspection while we found that some staff had left the service which improved the atmosphere in the short term, the provider had failed to address the concerns about the poor culture. They had not ensured staff understood how to report and escalate safeguarding concerns. There was no clear leadership in the service, with repeated changes of management. The provider had poor oversight of the service and had not identified that their own targets and timescales for change had not been met. Communication with people and their relatives was poor. The service did not actively engage the support of professionals to improve the quality of care for people unless it was at crisis point.

Action was not taken in response to safeguarding recommendations. The service failed to properly assess and manage risks, particularly risks in relation to people's distressed behaviours. People's risk assessments and care plans were out of date and did not contain accurate guidance on how to support people. Records were not reviewed following incidents. The provider had not reviewed the guidance and assessed risks in relation to Covid 19. Staffing levels had improved since the last inspection, however there were still significant gaps in the evenings where there were insufficient staff to support people safely. There were occasions at night when there were not enough staff on duty and on one of these occasions a serious incident had occurred which could have resulted in harm to people living at the service and staff.

The service did not apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons. There was a closed culture that did not support people to have choice and control. People were not supported to engage in meaningful activities either within the service itself or in the local community. People were not

supported to develop skills to support their independence.

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 inadequate (published 16 April 2020) and there were multiple breaches of regulation. 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.

This service has been in Special Measures since 15 April 2020.

Why we inspected
The inspection was prompted in part by concerns relating to notification of an incident which could have resulted in serious harm to staff and people using the service. These concerns related to the management of risk in relation to people's behaviours. When we followed up our concerns it became apparent the provider had not made the improvements they said they would make following our last inspection. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

The overall rating for the service has stayed the same. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heathers 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 breaches in relation to safe care and treatment, safeguarding, staffing, governance, notification of other incidents and duty of candour at this inspection.

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 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 overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

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 Care Act 2014.

Due to the Covid 19 epidemic the first day of inspection was carried out by visiting the service. The second days were carried out remotely. This means we made calls to staff and relatives away from the site and asked for documents to be sent to us.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Heathers 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. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager had left at the time of the last inspection and the provider had placed an interim manager in the service. The provider's operations manager was also based at the service and the chief operating officer was supervising the interim manager.

Notice of inspection
This inspection was unannounced.

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. The provider was not asked to complete a 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 one person who used the service and three relatives about their experience of the care provided. We emailed all staff at the service for feedback and received responses from 10 staff.
We spoke with 10 members of staff some of these were staff who had provided email responses, other staff we spoke to when we visited the service including the interim manager, the operations manager, deputy manager, and care workers.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two 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 gained feedback from three professionals who regularly visit the service.

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to safeguard people from incidents of abuse. This was a breach of Regulation 13 (Safeguarding Service Users from Abuse and Improper 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 13.

• At our last inspection we found serious incidents of abuse by members of staff, despite this, at this inspection we found the provider had not taken action to ensure staff had a clear understanding of how to safeguard people from abuse. There had been no additional safeguarding training or competency checks for staff.
• Staff had a basic understanding of what might constitute a safeguarding concern, but some needed prompting on the kind of incident they might refer. Staff were not clear on how to report safeguarding concerns outside of the organisation and could not recall what training they had completed. At our previous inspection we found managers did not always report safeguarding concerns externally as required by law. It is important staff understand how to appropriately report instances of abuse to safeguard people if managers fail to act on concerns raised by staff.
• We found incidents recorded of unexplained marks on people's bodies. These had not been investigated or reported to safeguarding. They were explained as being the result of distressed behaviour. However, this was not witnessed at the time and there was nothing noted in the records to indicate that such marks were a risk. This meant that the service could not be assured that these marks had happened as a result of distressed behaviour and not as a result of the actions of staff.
• The service had failed to follow the recommendations made by the safeguarding professional following the safeguarding investigation into the serious incidents of abuse.

People continued to be at risk of abuse, the provider had not taken sufficient action to safeguard people and assure themselves staff understood how to identify and report instances of abuse and poor practice. This was a continued breach of Regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong; Preventing and controlling infection

At our last inspection the provider had failed to assess and manage risks, including risks associated with distressed behaviours and action was not taken following safety incidents to ensure that incidents did not reoccur in the future. 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

• At the last inspection we found that positive behavioural support (PBS) plans and risk assessments were out of date and inaccurate. Following the last inspection, we requested the provider update the risk assessment and positive behavioural support plant for the person involved in the serious incident. The service had updated the risk assessment but not the PBS plan.
• On this inspection we found records, with the exception of the risk assessment noted above, had not been updated in line with the providers own action plan. PBS plans and risk assessments continued not to contain accurate and up to date guidance for staff on how to support people with distressed behaviours to keep them safe.
• Prior to our inspection there was a serious incident that potentially placed people using the service and staff at risk of harm. This incident was similar to incidents that had occurred just before our previous inspection which had also placed people and staff at serious risk of harm. We found staff had not been following the person's risk assessment at the time of this incident.
• People's risk assessments had not been reviewed and updated in a timely manner. One person had repeated incidents of distressed behaviour which put themselves and other people at risk. Record showed that action was taken to make the environment safer for example by removing objects that could be thrown, but there had been no action to review of this person's care plans or risk assessments despite the fact these had not been reviewed since 2018.
• Staff had completed fire safety training, however not all staff were clear about fire procedures despite fire risks being identified in the service. They did not all know who the fire marshal was on each shift and they did not know there was a 'grab' bag in the office which contained important information in the event of a fire. This meant staff may not have been able to keep people safe in the event of a fire.

• Some action had been taken in relation to concerns we raised about the administration of medicines at our last inspection. We reviewed the medicine administration records (MAR) for four people. People who were prescribed medicines 'as and when required' (PRN) and had been taking these on a regular basis, had their medicines reviewed and were no longer prescribed PRN medicines. However, one professional we spoke with expressed concern that there continued to be reliance on medicines rather support to manage people's behaviour.

• We observed staff were not following the most up to date guidance in relation to the Covid 19 pandemic for care homes. Staff were not using any additional personal protective equipment such as masks. The manager told us this was because some people became distressed if staff were wearing masks and it also hindered communication for some people. However, there was no risk assessment in relation to this and no consideration of alternative measures that could be taken to keep people safe from the virus.
• In one of the resident meetings it was recorded that a person had become distressed as they were worried about Covid 19. They had been reassured in the meeting, however there was no evidence of any other work with people to reassure them about the virus and how they could stay safe. There was no signage or use of easy read materials to help people understand.
• There was no assessment of what would happen if somebody did develop symptoms of Covid 19 or test positive. The service had not considered the possibility that some people or staff could test positive for Covid 19 but not display any symptoms and had no measures in place to mitigate this risk.

• Staff told us there were no additional cleaning routines in place as a result of the pandemic, for example cleaning of high touch surfaces, such as door handles. Record of daily checks had not always been completed by senior staff to ensure cleaning schedules were carried out.

We found the provider did not have robust systems in place to assess and manage risks, including risks associated with distressed behaviours and risks associated with Covid 19. The provider did not take action following safety incidents to ensure incidents did not reoccur in the future. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• MAR charts indicated people had received their medicines as they were prescribed.

Staffing and recruitment

At our last inspection the provider did not ensure there were sufficient staff with the skills and knowledge to support people. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18

• There were not always enough staff to support people safely at all times during the day.
• Most staff who worked during the day time finished their shift at 8pm, when the night shift started. However, there were less staff on duty at night which meant there were only 4 or 5 staff on duty after 8pm. Several people were assessed as requiring one to one support or two to one support during waking hours. This meant that in the evenings there were not enough staff to support people safely in accordance with their assessed needs.
• According to people's assessed needs the service should have at least four staff on duty at night. On two nights in the month before our inspection there were only three staff on duty. On one of these nights there was a serious incident that could have resulted in serious harm to people using the service and staff.
• Staff rotated who they were supporting each day. This meant they only stayed with people for four hours and then would move on. Relatives told us their family members found this difficult. One relative told us, "This time limit…if they are playing games, they all of a sudden have to stop and the next [staff member] who comes might not want to do anything like that with [family member]."

The provider failed to ensure there were sufficient staff with the skills and knowledge to support people at all times in the day. This was a continued breach of Regulation 18 (Staffing) of the Heather and Social Care Act (Regulated Activities) Regulations 2014.

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 Inadequate. At this inspection this key question has remained the same. 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.

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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

At our last inspection the provider had failed to create an open culture where concerns could be reported and acted upon. The provider had failed to effectively monitor the quality of care delivered by staff. This was a breach of Regulation 17 (Good Governance) of the 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 17

• At our last inspection we found there was no provider oversight of the service. Senior members of staff and the former registered manager had completed some audits but there were no checks by the provider and as a result they had failed to identify many of the serious concerns within the service. At this inspection we found this was still the case.
• The provider had created several action plans following our previous inspection. Actions not completed in the first action plan were simply put into future action plans with revised deadlines. This meant important action had not been taken in a timely manner and the provider failed to meet their own deadlines.
• There were no robust governance and auditing system by the provider. This meant the provider continued to be unaware of the slow progress at the service. For example, they were not aware no work had been done to update risk assessments and PBS plans.
• There was inconsistent leadership at the service. The registered manager had left at the time of the last inspection. An interim manager had been appointed, this person was replaced by another interim manager after our inspection visit and the provider told us they were recruiting for a permanent manager.
• The provider told us they would put in the chief operating officer to oversee the service and supervise the interim manager. They told us this person would monitor all incidents and accidents at the service to ensure concerns were reported and acted on immediately. There had been a serious incident which could have resulted in harm to people living at the service and staff. The providers representative who was supervising the interim manager had not been made aware of the incident until we called them two days later.

• Relatives told us changes in management and staffing were not always communicated with them. One relative told us they had found out from a social care professional about a change in management. Relatives told us they received no regular updates about the service and were only updated about their family member's care when they rang the service.
• At our last inspection we found evidence of a closed culture where staff failed to report concerns and escalate them to managers. Staff we spoke with told us some staff had left the service which had improved morale and the atmosphere, however there was no evidence of active work done by the provider to improve the culture in the organisation and prevent abuse happening again.
• Managers told us they were assessing the competence of staff and intended to design a new safeguarding training course for staff based on the competency assessments. However, this had not been delivered and staff continued to complete online safeguarding training which was the training in place prior to our last inspection. Given the seriousness of the concerns we found at the last inspection additional training on safeguarding should have been delivered to staff as a matter of urgency in order to ensure staff were clear about when and how to report and escalate concerns.
• The provider was not following their own action plan to improve the service and keep people safe. In their action plan the provider had said, 'Staff to receive coaching around incident reporting and making safeguarding referrals.' This was to be completed by 30 March 2020 and had not yet been completed.
• There were no additional competency checks on staff to make sure they were following best practice and delivering care safely. The only competency checks on staff carried out were in relation to administration of medicines.
• There were no systems in place to monitor staff if they had been subject to disciplinary procedures.
• There was no culture of learning when things went wrong. While incident reports did now contain management actions these generally commented on the fact the care plan was being followed. The managers showed us an 'analysis' of incidents over the past three months. However, this was just a summary of the number of incidents involving each person. There was no associated action plan to show learning from incidents to reduce future incidents. For example, there were no reviews of care plans and risk assessments or referrals to professionals who may be able to provide additional support or expertise.
• There was no oversight or assessment of risk in relation to Covid 19.
• Staff told us they had not received guidance from the provider about Covid 19 and they said people using the service learned about the virus through 'watching TV.'
• The service was not supporting all people to maintain contact with their families during the Covid 19. Some people were supported with video calls to family, but relatives told us some calls were missed. Where this type of communication was not possible there were no additional measures in place, such as newsletters or photographs to help people stay in touch.
• The service had no plans for enabling people to participate in meaningful activities beyond a walk, bike ride or car ride. Professionals we spoke with told us they felt the service hadn't given much thought to this and had not been as creative as other services they had seen in their response to restrictions on movement during the pandemic.
• The provider had taken steps to review staffing levels at the service. However, there were still gaps in each day where staffing levels were low.
• The provider had reviewed the induction process for new and agency staff in order to familiarise themselves with people's needs. However, it was unclear how robust this was given that many of the records and risk assessments were out of date and did not contain key information about people's needs.
• The provider was not following guidance in relation to Registering the Right Support. At the time of the inspection there were restrictions on access to the community due to Covid 19. However, it was not clear what action the service had taken to support people to maintain links with the community in other ways. There were no risk assessments or care plans in place about how they would support people to engage in alternative meaningful activities, including socialising within the service during the Covid 19 pandemic.

The provider had failed to take action to improve the culture at the service and to ensure action was taken in response to concerns. The provider did not have a robust governance system in place for them to monitor the quality of care delivered by staff. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The service had reviewed planning in relation to people's meals in accordance with people's preferences and had created four weekly menu plans taking account of cultural needs with recipes for staff and pictures to help people to understand the options on offer.
• The service had employed staff to support people with particular cultural needs.
• Following our inspection and following a meeting with safeguarding, the provider had begun to take measures to address the concerns including speaking with each member of staff to ensure they understood how to identify and report safeguarding concerns.
• The service had set up resident meetings to engage people who lived at the service. However, staff told us it was hard for people to meaningfully participate in these meetings due to their complex communication needs. There was no further consideration into how people could be engaged using their communication methods.

At our last inspection the provider had failed to report allegations of abuse to the commission. This was a breach of Regulation 18 (Notification of Other Incidents) Care Quality Commission (Registration) Regulations 2009.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

• We found incident records which referred to unexplained marks on people's bodies. These incidents had not been investigated, had not been reported to safeguarding and had not been notified to the commission.

Failing to report safeguarding concerns to the Care Quality Commission is a continued breach of Regulation 18 (Notification of Other Incidents) Care Quality Commission (Registration) Regulations 2009.

At our last inspection the provider had failed to be open and honest in regard to safety incidents at the service. This was a breach of Regulation 20 (Duty of Candour) of the 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 20

• Where we found examples of incidents relating to unexplained marks on people's bodies there was no management action taken to investigate the incident or to inform and apologise to relatives.

Failing to be open and honest with regard to safety incidents is a continued breach of Regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
• There was no evidence of sustained working with professionals to support people with their behaviours and complex needs. Support from professionals was engaged at crisis points.
• The service had worked with other professionals following a serious safety incident at the service.
• At the time of inspection, the service had engaged the support of a psychologist to assist with the

development of Positive Behavioural Support Plans and care plans in easy read format.

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 provider failed to report safeguarding concerns to the Care Quality Commission. Regulation 18 (1)

The enforcement action we took:

Variation of condition to remove this location from the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have robust systems in place to assess and manage risks, including risks associated with distressed behaviours and risks associated with Covid 19. The provider did not take action following safety incidents to ensure incidents did not reoccur in the future. Regulation 12 (1) (2) a b g h i

The enforcement action we took:

Variation of condition to remove this location from the provider's registration

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 People continued to be at risk of abuse, the provider had not taken sufficient action to safeguard people and assure themselves staff understood how to identify and report instances of abuse and poor practice. Regulation 13 (1) (2) (3)

The enforcement action we took:

Variation of condition to remove this location from the provider's registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to take action to improve the culture at the service and to ensure action was taken in response to concerns. The provider did not have a robust governance system in place for them to monitor the quality of care delivered by staff. Regulation 17 (1) (2)

The enforcement action we took:

Variation of condition to remove this location from the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider failed to be open and honest with regard to safety incidents. Regulation 20 (1) (2) (3)

The enforcement action we took:

Variation of condition to remove this location from the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient staff with the skills and knowledge to support people at all times in the day. Regulation 18 (1)

The enforcement action we took:

Variation of condition to remove this location from the provider's registration