Heartwell Care Ltd

Heartwell House Residential Care 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

Heartwell House Residential Care Home is a residential care home providing personal and nursing care to 11 people with mental health needs. The service can support up to 13 people in three adapted buildings.

Heartwell House is also registered to provide domiciliary care, though currently has not commenced providing this service.

People's experience of using this service and what we found
People were not always provided with safe care. People were exposed to the risk of acquiring infectious diseases including COVID-19 because infection control procedures were not managed safely. The service has had a number of outbreaks of COVID-19. Despite this, lessons were not learned and, government guidance not followed to minimise the risk of further outbreaks. Personal protective equipment (PPE) was not always worn correctly, and some staff did not follow the providers dress code and travelled to and from work in their uniforms.

There were some medicines that were not managed properly, however, we did not find anyone had been harmed. Environmental risks were not addressed. An electrical socket had remained unrepaired since February 2020, there were other areas of maintenance which the staff had recorded were in need of repair, but these had not been followed up or made safe. Cleaning mops and buckets were not stored properly and flooring and walls were not adequate that would allow proper cleaning and disinfection. By the second day of the inspection a number of the above areas had been improved.

Staff were not supported in their roles and, when they raised concerns they were not always listened to. Supervisions, appraisals and team meetings were undertaken and staff were recruited safely.

The service was not always well-led. Leadership and oversight of the service was poorly coordinated and records to support effective quality assurance of the service were not in place. Information in some documents was inconsistent and staffing numbers did not allow for people to be supported properly. Management communication with staff was inconsistent, where staff did not feel well informed or valued.

Relatives we spoke with had mixed opinions about the home in relation to communication, and questionnaires and newsletters were distributed periodically.

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 January 2020).

Why we inspected
The inspection was prompted in part due to whistle blowing concerns received about infection control and

staffing. A decision was made for us to inspect and examine those risks.

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

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report for details.

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

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 people's safe care and treatment and poor governance. Please see the action we have told the provider to take at the end of this report.

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 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.

Heartwell House Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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
This site visit was carried out by two inspectors. Phone calls to people's relatives were undertaken by 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 expert had experience of people with mental health needs. Phone calls to staff were made by a third inspector.

Service and service type
Heartwell House Residential Care 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, and both were looked at during this inspection.

Heartwell House is also registered as a domiciliary care agency. It can provide personal care to people living in their own homes and specialist housing. The provider has not commenced providing this service at this time.

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 notice of the inspection just before we entered the home. This supported the service and us to manage any potential risks associated with 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 used all of this 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 saw six people who used the service, however we were unable to speak with any people at the inspection. We observed the interactions between people and staff. We reviewed a range of records. This included people's care records and multiple people's medicine 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 regular tests. We asked the registered manager to send documents we were unable to view on the inspection. Though some of these were forwarded a number were not.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We made telephone calls to nine relatives and four staff.

Requires Improvement

Is the service safe?

Our findings

Safe – this means 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.

Preventing and controlling infection; Learning lessons when things go wrong

- People were placed at serious risk of acquiring infectious diseases. Despite the service having had previous outbreaks of COVID-19, government guidance was not followed to minimise the risk of further outbreaks. Cleaning mops and buckets were not stored properly and flooring and walls were not sealed that would allow proper cleaning or disinfection.
- Some staff were observed to be wearing inappropriate clothing and a cloth mask. This was in direct contradiction of the homes' dress code and current government guidance.
- There was an infection control audit performed by the registered manager, this was not detailed enough to ensure areas were cleaned or disinfected properly. Cleaning schedules were not detailed to ensure areas were disinfected and the potential risks reduced.

Using medicines safely

- Systems in place to ensure the proper and safe management of medicines were not robust. Records showed that one person refused their medication when they had a relapse of their mental health needs. There was no guidance for staff in the person's care plan when this happened.
- One person had regular PRN (as needed) medicines and staff were expected to complete the back of the Medication Administration Record (MAR) when this had been administered. This had not been completed for all occasions when the medication had been administered. Staff told us people were given their PRN medicines without any alternatives such as deflection or talking with the person first. We spoke with the registered manager about this who said there were occasions where PRN medicines were given immediately. This had been agreed by the GP in advance.
- The PRN audit check did not record what 'as needed' medicine was administered.
- The MAR chart for one person showed they were prescribed a topical cream. There were no instructions of where to apply the cream and how often it should be applied. We spoke to the registered manager about this who sent the body map following the inspection.
- Medicines audits were not effective at identifying errors and gaps in records. Some staff told us they had not received accredited medicines training.
- One person had a hospital passport that recorded a list of their medicines. They also had a grab sheet (information taken with people to hospital) that also recorded a list of their medicines. However, there were differences in the medicines recorded in both documents. We spoke with the registered manager who told us this would be brought up to date.

The provider failed to adequately protect people from the risk of infection and had not ensured the safe management of medicines. This was a breach of regulation 12 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

● We had conflicting opinions from people's relatives about the safety in the home. One relative said to us, "I was concerned about how [named] contracted Covid. I have asked how [they] could have contracted it and they [staff] told me they were unsure about how it was transmitted they did say that they had a deep clean but it didn't fill me with confidence." A second relative said, "I feel that they are keeping [named] safe in the home."
● By the second day of the inspection a number of the above areas had been improved.
● We were assured that the provider was accessing testing for people using the service and staff.

We have made recommendations where appropriate PPE can be sourced which takes account of people's religious observances.

● People's clothes and laundry was double bagged, tied and stored securely awaiting laundering. Staff told us they laundered one person's clothes at a time. This reduced the potential for cross contamination of people's clothes.
● Procedures were in place, where possible, to socially distance people within the service. One person displaying COVID-19 symptoms was isolating in their bedroom whilst other people used the communal areas. However, some of the seating in communal areas was not disinfectable.

Assessing risk, safety monitoring and management
● Regular safety checks had been carried out on the environment and on the equipment used to care for and protect people. However, this did not reveal an electrical socket had remained unrepaired since February 2020. There were other areas of maintenance which the staff had recorded were in need of repair, but these had not been followed up or made safe.
● Emergency evacuation plans were in place to ensure people were fully supported in the event of the building being evacuated.
● When calling the relatives and staff we were made aware of some concerns. These included concerns for people on upper floors who were unsafe to use the stairs as their balance was poor. Also whether shower trays were safe for people who needed staff support. We discussed these issues with the registered manager who recognised them and acted appropriately to make changes.

Systems and processes to safeguard people from the risk of abuse
● Most people's relatives told us they felt their relation was safe.
● People did not have access to a bedroom door lock or were in a secluded part of the home. We were unable to speak with any people at the inspection but one person's relative told us they were not sure people could be evacuated in an emergency. We followed this up with the Leicestershire Fire and Rescue Service (LFRS) who visited the home and were satisfied with the Fire Risk Assessment and any plans to evacuate people.
● The registered manager had systems and processes in place to ensure people using the service were safeguarded.
● Staff had received training in safeguarding people and demonstrated their knowledge and responsibilities for ensuring peoples safety. However, staff told us they would like further training on safeguarding and behaviour that challenged. We spoke with the registered manager who agreed to consider further person to person training.

Staffing and recruitment
● Staff were not employed in numbers to support people safely. Staff rotas demonstrated staffing levels at

the weekend were not suitable to meet people's physical and emotional needs, as well as cooking and cleaning. One relative said, "Sometimes they don't supervise [named] helping to choose clothes for the day, so [they] wears the same clothes. Changing clothes is our main concern, [named] needs encouragement but doesn't get it, clothes can get a bit dirty through food dropping on them, that sort of thing."

● When we discussed this with the registered manager, they told us they had not increased staffing numbers in response to the outbreak of COVID-19. The current cleaning and disinfection programme was not sufficient to reduce potential risk of the spread of infection. They told us this was to be reviewed and a housekeeper employed to provide staff with more time to spend with people.

● The registered manager followed the company's policies and procedures in safe recruitment and selection processes. Staff had the appropriate checks in place prior to commencing employment at the home.

● When we returned to inspect for a second day the provider had increased the weekend staffing numbers; put in place a more detailed cleaning schedule and removed a number of seats from communal areas. That allowed staff to disinfect the remaining seats in public areas.

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 deteriorated to requires improvement This meant people's needs were not met through good organisation and delivery.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service was not well led. The registered manager had auditing systems in place to monitor parts of the service, however, these were not sufficiently detailed and were not used effectively to assess risk on a regular basis or drive improvements.
- We saw evidence of gaps in recording in medicine charts, suicide risk assessments, hospital passports and safety checks. There were a number of records in the office which were to be transferred onto a computer records that would allow detailed analysis and reveal any patterns. The registered manager said they did not have time to complete this. This put people at risk due to inconsistent monitoring.
- There was a monthly medicines audit however, this audit had not identified concerns that were found during the inspection in relation to medicines management.
- Staffing levels at the weekend were insufficient to care for people safely. At the time of the inspection the registered manager said there was a plan in place to recruit to vacant posts including care assistants and a housekeeper but were just waiting confirmation from the provider to employ the staff.

We found no evidence people had been harmed however, the provider failed to have sufficient systems to improve the quality and safety of care and maintain a good oversight. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- On our return to inspect for the second day, we saw that care staffing numbers had been increased at weekends.
- The registered manager understood the regulatory requirements to report incidents and events to CQC. Our records showed these had been submitted when required.
- When calling the relatives and staff we were made aware of some concerns. These included an allegation of favouritism towards some staff. Fresh food was not always available, for example fruit, as shopping was done on a monthly basis; whether some people had restricted meals and given small food portions, and there was little time for people to have one to one support or regular activities. The registered manager said they would act to resolve these difficulties and communicate the outcomes to people and their relatives in the forthcoming newsletter.

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;

- We had mixed comments about staff communications. Some relatives spoke positively about the

registered manager and staff, and knew who to speak with if they had any issues. One relative said, "The registered manager does a really good job and has a rapport with [named]. I can't speak highly enough of her and the staff; there is communication on a daily basis and they will contact me if there's any problems." Another relative said, "Heartwell [staff] said they contacted me but they didn't leave any message. I rang again and was told that one of the managers would call back but they never did. They may have called but didn't leave a message so how do I know?" We discussed this with the registered manager who said that a relative had requested information which was confidential and they were unable to pass this on.

● The previous inspection report and rating was displayed within the service.

● The registered manager was aware of, and the provider had systems in place to ensure compliance with duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment, and authoritative bodies need to be informed.

● Complaints were appropriately recorded. However, relatives we spoke with told us their concerns were not listened to nor were they contacted back to discuss their concerns. We spoke with the registered manager who said, that staff had recorded information and passed it onto them. There were some concerns that were being investigated and feedback would be provided to the relative.

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

● Staff demonstrated that they knew people's needs, their likes, dislikes and personal preferences.

● Staff told us they did not feel supported in their roles. More than one staff member told us the management team did not value them and sometimes did not speak to them. One staff member told us that they were shouted at. We discussed this with the registered manager who said the staff were valued, and had pulled together through the recent pandemic.

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

● People and their relatives were asked for feedback on the service. Surveys were sent out twice a year and feedback sent to relatives. The registered manager also sends out newsletters, however stated that due to the recent pandemic the majority of communication was by phone. The next newsletter is ready and will be sent before the end of the year.

● Staff received group and individual supervisions and there were regular two monthly staff meetings.

● People's communication needs were met. Information was made available in different formats to meet individual needs. For example, easy read or pictorial. Many of the staff were bi-lingual and were able to communicate with all those in the home.

Continuous learning and improving care; Working in partnership with others

● We could see the registered manager reviewed the service provided for people. However, this was inconsistent, and improvements were not communicated well with staff. Staff told us the management team were not supportive and did not communicate consistently. We spoke to the registered manager about this who said there had been some confusion between staff but a revised and more detailed handover process had begun and this would clarify discussions.

● The registered manager, deputy and care staff were open and transparent throughout the inspection and some areas of concern were addressed immediately during the inspection.

● The registered manager demonstrated how the staff worked in partnership with local hospitals, commissioners, the local authority safeguarding team and other healthcare professionals to try to meet people's needs consistently.

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 adequately protect people from the risk of cross infection and cross contamination. The provider failed to adequately protect people from the risk of staff administering incorrect medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have sufficient systems to improve the quality and safety of care, maintain a good oversight and drive improvement.