National Autistic Society (The)

Heath Rise

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
Heath Rise is a care home providing personal care to 4 people with a diagnosis of learning disabilities and/or autism at the time of the inspection.

People's experience of using this service and what we found
Risks to people had not been consistently assessed or mitigated. Risk assessments were not always kept up to date. Equipment used to reduce risks had not been kept in good working order.

Infection control procedures required improvement. Not all procedures were followed regarding taking staff and visitors temperature. Cleaning schedules had gaps in the records.

Records of care tasks contained gaps in the recording. These issues had not been identified prior to the inspection.

Systems and processes to ensure oversight of the service required improvement. We found limited audits completed and most audits had not been completed since November 2020.

People were supported by staff who knew them well and had been safely recruited. Not all staff had received up to date training. However, the registered manager was in the process of ensuring training was updated.

People received their medicines as prescribed and staff were competent to administer medicines.

Care plans were person centred and detailed for each person. Information was given to people in a format that suited their needs.

The service had not received any complaints within the past 12 months. Complaints, when received, were dealt with appropriately and within the providers timeframe.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was able to demonstrate how they were meeting the underpinning principles of Right support,

right care, right culture.

Right support:
• Model of care and setting maximises people's choice, control and independence
Right care:
• Care is person-centred and promotes people's dignity, privacy and human rights
Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives

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 15 January 2019).

Why we inspected
We received concerns in relation infection control and a COVID-19 outbreak. 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

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement. 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 Heath Rise 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 monitor the service.

We have identified breaches in relation to risk assessments, infection control 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.

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.

Heath Rise

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
The inspection was carried out by one inspector.

Service and service type
Heath Rise 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 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
This inspection was unannounced.

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.

During the inspection
We were unable to speak to people using the service. We spoke to one relative about their experience of the

care provided. We spoke with five members of staff including the registered manager, deputy manager, care workers and the human resources manager.

We reviewed a range of records. This included three people's care records and two people's medication records. A variety of records relating to the management of the service, including recruitment, oversight, 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.

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; Systems and processes to safeguard people from the risk of abuse;Preventing and controlling infection

- Risks to people had not consistently been assessed and mitigated. For example, people did not have risk assessments in place regarding risk of scalding from water or radiators. We found that radiators did not have covers on them and water temperatures had not been checked since January 2021.
- Fire extinguishers were out of date or not in use. The provider had received a report from an external fire serving in April 2020 stating they required replacing. This put people at risk from fire.
- Risk assessments in place had not always been updated as required. For example, people's personal emergency evacuation plans [PEEP] had not been updated after a fire drill. This was an action required after the drill.
- Unexplained bruises or injuries had not always been investigated or follow up checks completed. This put people at risk of harm.
- We were not assured that the provider was preventing visitors from catching and spreading infections. On the first day of inspection the process of checking visitors were safe from infections before entering the property was not followed.
- We were not assured that the provider was promoting safety through hygiene practices of the premises. For example, we found multiple gaps in cleaning records and not all cleaning records could be found for each day.
- We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. For example, the procedure for staff taking their temperature before working was not consistently followed.

The provider had failed to assess risk and do all that is practical to mitigate risks and to ensure prevention, detection and control of the spread of infections. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider's infection prevention and control policy was up to date.

Staffing and recruitment

● Staff were recruited safely, and the necessary checks were completed such as references and Disclosure and Barring Service [DBS] check was completed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.
● The service had appropriate staffing levels on each shift to ensure people were supported safety within the home and in the community.

Using medicines safely
● People received medicines as prescribed. Staff completed weekly medicine administration record audits and daily stock checks to ensure records were accurate.
● Medicines were stored, administered and recorded appropriately.
● As required medicines had protocols in place and staff followed instructions. When as required medicines were administered staff recorded the reason and outcome.

Learning lessons when things go wrong
● The provider had systems in place to identify trends and patterns for accidents and behaviours. This information was shared with staff to ensure lessons were learnt.

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.

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

- Systems and processes to ensure the recording of care tasks was completed required improvement. We found gaps in the recording of daily notes, handovers and for the monitoring of bowel movements. These gaps had not been previously identified therefore no actions had been implemented to reduce the risk of reoccurrence.
- Some audits to ensure oversight of the service had not been completed since November 2020. The infection control audit completed stated all cleaning records were completed, However, we found multiple gaps in these records.
- The concerns found under the safe domain regarding risks to people and infection control had not been identified by the registered manager prior to inspection.
- We found no evidence of capacity assessments being completed for COVID-19 testing for people using the service. We also did not find any evidence of consent to share information being recorded in people care files.
- We found no evidence of people or relatives being asked to feedback on the service.
- Not all staff had completed up to date training. We found three staff had out of date training. The registered manager was in the process of booking the required training.

We found no evidence that people were harmed, however, the provider had failed to assess, monitor and improve the quality of the service. This 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People had detailed person-centred care plans in place which included likes, dislikes, communication needs and a section on 'how best to support me'. Staff knew people well and supported them in line with their wishes.
- People had choice and control over their life, for example, they were able to choose activities, meals and staffing preferences.
- Information was provided in different formats to ensure people could understand the information received. This included easy read and pictorial formats.

● Staff told us they felt supported within their roles. However, the registered manager had been not been at work for four months, so they had multiple people to contact when support was needed.

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 service had not had any complaint made within the last 12 months. When a complaint was made the registered manager responded appropriately and within the providers recorded timeframe.

● Staff and relatives told us they knew how to complain and would do so if required. People were offered an easy read complaints form and guidance.

● The registered manager understood their duty of candour responsibility. However, they had not had to complete any to date.

Working in partnership with others

● Staff worked closely with the local learning disability community team. We saw referrals were made as required to professional and advise followed.

● Staff supported people to access healthcare professionals and worked closely with the local GP to ensure people attended appointments.

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 had failed to assess risk and do all that is practical to mitigate risks. The provider had failed to ensure prevention, detection and control of the spread of infections.

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 assess, monitor and improve the quality of the service.