Miss V Etheridge

Heronlea Residential Home

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
Heronlea Residential Home is a residential care home providing personal care and accommodation for up to 13 older people, most of whom were living with dementia. At the time of our inspection there were 12 people using the service. The bedrooms for the service were across 2 floors, some of which were shared. There were 2 communal lounges, a shared bathroom on the ground floor and an enclosed garden. A people carrying lift was also in place.

People's experience of using this service and what we found
Management of risk was poor. Risks relating to people's individual care needs had either not been identified or were poorly planned for. This included poor management of falls and distressed behaviour. Safeguarding incidents had not been identified or reported to the relevant authorities.

Environmental risks were also not managed appropriately which placed people at risk of harm. Guidance provided for staff about what action they needed to take in the event of an emergency was not detailed, and people's personal emergency evacuation plans contained incorrect information. Recording of accidents and incidents was poor, and no analysis or learning took place from incidents to improve practice.

Concerns were noted with the management of medicines, particularly around where medicines were prescribed to be given 'as required' medicines. However, medicines were stored safely.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Governance processes to monitor and assess the safety and quality of the service remained ineffective and failed to drive improvement. The registered manger was not clear about the regulatory requirements, and did not submit notifications of reportable incidents in line with the regulatory requirements.

Further improvements were still required in relation to the recruitment of staff. Application and recruitment procedures were not sufficiently robust to ensure the suitability of applicants.

People's care was not planned in a person-centred way, and did not ascertain their wishes and aspirations. Staff did not support people in a way which promoted their independence.

Staff training provision had improved, however, the effectiveness of the training did not translate into practice. Staff felt supported in their work.

Improvements had been made in relation to infection prevention and control procedures, and the kitchen had undergone some remedial works.

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 29 September 2021) and was placed in Special Measures. We imposed conditions on the provider's registration which required them to submit us monthly action plans. At this inspection we found the provider had not made the required improvements and remained in Special Measures.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 11, 17 and 27 August 2021. Breaches of legal requirements were found. The provider was in breach of regulations Premises and equipment, Safe care and treatment, Fit and proper persons employed and Good governance.

We undertook this focused inspection to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains inadequate.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heronlea Residential Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, need for consent, safeguarding people from abuse, good governance and person-centred care 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Heronlea Residential 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 Health and Social Care Act 2008.

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 inspection was carried out by 2 inspectors.

Service and service type
Heronlea is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Heronlea is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 7 December 2022 and ended on 20 December 2022. We visited the service on 7 December 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
Most people using the service were unable to tell us about their experience of the care provided at Heronlea. We made observations of the care being provided in the communal areas of the service. We spoke with the registered manager, deputy manager and one member of staff.

We reviewed the care records for 9 people, and the medicines records for 7 people. We looked at 3 staff recruitment files and supervision records. A range of records relating to the quality, safety and day to day running of the service were also looked at as part of this inspection.

After the inspection
We continued to seek clarification from both the registered manager and deputy manager in relation to the evidence found. We continued to seek feedback about the service and spoke with the relatives of 2 people and 3 members of staff over the telephone. We also received written feedback from the GP and spoke with the Quality Monitoring Officer from the local authority quality assurance team.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

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

At our last inspection the provider had failed to implement systems to identify and manage risks relating to people's health and welfare. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

● Risks to people's individual needs were not always assessed. A review of incident records and care records showed that some people showed distressed behaviour which led them to hurt others. There were no risk assessments in place to determine what action staff could take to mitigate this risk to keep people safe.
● We observed two people arguing, as the argument became louder, a member of staff who was present in the vicinity eventually attended, but did not speak with either person about the incident, nor provide support to either person to check how they were.
● Assessment of people at risk of falls was poor. The assessment used to determine falls risk was a checklist and there was no scoring system to ascertain the level of risk. This meant preventative measures had not been put in place. This was of concern as incident records showed two people had sustained more than one fall recently and risk assessments had not been reviewed to show what preventative measures had been put in place.
● Analysis of falls did not take place. Whilst a log of falls was kept, further analysis to identify themes and trends had not been completed. For example, looking at the times and locations where the falls occurred to support the management team to identify risks and put measures in place to mitigate them.
● Risks regarding the sharing of rooms had not been considered. There were three shared rooms, and all were occupied. One person's care needs assessment suggested they would benefit from having their own room, despite this, they shared a room with another person.
● Personal emergency evacuation plans did not contain the correct information about the support people would require to evacuate the building in an emergency. This placed people at risk of receiving inappropriate and unsafe support if the service required evacuation.
● People's understanding and ability to use the call bell system had not been explored. This is good practice when supporting people living with dementia and who may need to summon assistance in an emergency.
● Risks within the environment were not mitigated. People living with dementia had access to areas of potential risk such as the laundry and the kitchen. We observed cats were living in the service. One person required treatment after being bitten by one of them. The risk assessment in place regarding the cats was

not sufficient.
● There was inadequate analysis of accidents and incidents. A review of records showed incidents had not been reviewed to facilitate learning and a review of the management of risk. Two incidents had no reviews at all, and the review of one of the incidents contained conflicting information to the initial report. This meant the provider had not learnt from previous incidents and put measures in place to mitigate the risk.
● Medicine administration records (MARs) did not always contain the correct information. For one person's medicine, the MAR stated the medicine should only be given when required (PRN). We questioned why this was given regularly and the registered manager told us that two of the doses were to be given regularly and a third as required. The registered manager was unable to show any evidence from the GP to confirm this.
● Staff were not always recording the reasons why they administered PRN medicine to people. We found this to be the case for two people. It is good practice to document this information as it can inform if the person may need the medicine to be administered on a regular basis and to ensure consistency of administration.
● Assessments of pain were not detailed. The assessments detailed staff should offer PRN pain relief if people were experiencing 'common pain' and seek medical attention if experiencing 'acute pain'. The assessment did not provide guidance on these two descriptors of pain. Pain assessments also failed to document how people would display they were in pain.
● Care plans relating to how people liked to take their medicines were generic and we saw the same information in other people's care records. Therefore, we were not assured people's preferences had been fully assessed and met.

Assessment of risk remained poor and people were not protected from the risk of harm. There was insufficient recording and analysis of accidents and incidents. There was some poor practice in relation to the management of people's medicines. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Medicines were stored safely, and staff had received training in the safe administration of medicines.
● There were no gaps on the MARs where staff signed to show a medicine had been given.

At our last inspection the provider had failed to maintain the premises and equipment in line with safety standards. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found improvement had been made and the provider was no longer in breach of this regulation.

● Since our last inspection improvements had been made to the kitchen, this included repairs to work surfaces. We also saw lockable cabinets had been put in place in people's rooms to safely store items such as razors and topical medicines.
● We found maintenance checks had improved, this included servicing of manual handling equipment and gas appliances.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding incidents were not identified and reported to us. During a review of records we identified two safeguarding incidents which had not been reported to the local authority safeguarding team, who were responsible for investigating concerns of abuse. Therefore, we were not assured the registered manager or staff team had a good understanding of what constituted abuse and their responsibilities in relation to reporting such incidents.

● The lack of reporting safeguarding incidents meant there were missed opportunities to work with other professionals to review and mitigate such incidents in order to keep people safe.
● Whilst staff had received training in safeguarding, conversations with them showed there were gaps in their knowledge around this.

The provider had failed to ensure people were protected from the risk of abuse and report safeguarding incidents to the relevant authorities. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not working within the principles of the MCA. There were no decision specific assessments of people's capacity detailed in people's care records. Therefore, we could not be assured thorough assessments of people's capacity had taken place prior to the submission of applications to deprive people of their liberty.
● The registered manager told us every person living in the service did not have capacity to make decisions about their care and treatment. However, a review of care records showed one person did have capacity, but consent forms had been signed by a relative rather than the person using the service. This was not in line with the principles of the MCA.
● Where people lacked the capacity to make decisions, there were no best interest decisions in place which should detail why care and treatment should be delivered in the absence of being able to obtain informed consent.
● There was no documentation in place to detail the rationale for the use of restrictive practice. This included alarming people's doors and the use of pressure mats to alert staff of people's movements.
● Our conversations with staff showed they did not have a good understanding of the MCA and how it applied to their practice.

The provider failed to adhere to the principles of the Mental Capacity Act. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing and recruitment

At our last inspection the provider did not complete the required checks to ensure suitability and the character of new and existing staff. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found improvement had been made and the provider was no longer in breach of this regulation. However, further improvements were still required.

● Some applicants had submitted incomplete application forms and were offered an interview. The

interview questions were not tailored to fully assess the applicant's skills and knowledge.
● Background checks of employees had improved. We saw references had been sought and criminal checks with the Disclosure and Barring Service (DBS) had been undertaken. The DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps to make safer recruitment decisions.
● We were not assured there were enough staff deployed to meet people's needs. Two care staff worked each shift. Some people required the support of both staff with their care needs.
● We observed incidents where staff did not support people appropriately. One person was trying to walk through a stable-style door which was not secured, the top part of the door was swinging about and could have caused an injury. We also observed an argument between two people, and one person trying to move people in their wheelchairs.

Preventing and controlling infection

At our last inspection the provider had failed to implement measures to prevent the risk and spread of infection. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found improvement had been made and the provider was no longer in breach of this part of the regulation.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People were supported to have visitors without restriction, and measures were in place to screen visitors for signs of infection before entering the service.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. 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.

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

At our last inspection the provider had failed to implement systems to assess and monitor the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17 in relation to good governance.

- At the last inspection we found the registered manager did not understand their regulatory responsibilities. At this inspection, we found this still to be the case as there were no processes in place to ensure safeguarding incidents were identified and reported to the local authority safeguarding team.
- Adequate governance systems to assess and monitor the quality and safety of the service had still not been implemented. Risks in relation to people's individual safety, and that of the environment had still not been identified and mitigated.
- There was no improvement plan in place, despite the inadequate rating at the last inspection. Whilst some oversight had been put in place, this was ineffective in identifying areas for improvement.
- The continuing poor quality of risk assessments relating to people's individual needs and the environment had not been identified as an area for improvement until we raised this as a concern. We were not assured the registered manger and staff were able to independently identify and manage risks to keep people safe.
- The business continuity plan, which should detail what action staff need to take in the event of an emergency situation was not sufficiently detailed. For example, if there was a power failure, the plan did not detail where torches were kept. There were no plans detailed for an immediate place of safety for people to go to, instead a generic contact for the Local Authority duty team was listed. In addition, staff did not know the location of the plan to access it if there was an emergency.
- The registered manager and staff did not follow the safeguarding policy for the service in relation to the reporting of incidents and protecting people from harm.
- The registered manager told us they did not use a dependency tool to determine the staffing levels required to safely meet people's needs. This demonstrated a poor understanding of adequate deployment of staff to meet people's needs and maintain people's safety.

● There was poor oversight of the recruitment for new staff. The application and interview process were not sufficient in assessing applicant's experience and knowledge for the role they had applied for.
● The complaints log did not detail the nature of the complaints and was not clear what the outcomes were, and if any learning had taken place.
● The registered manager did not have a good understanding of CQC's remit. Contracts of employment stated staff may apply to the CQC if they are dissatisfied with the outcome of any grievance. Individual employment matters do not fall within our remit.
● The continued non-compliance with the regulations found at this inspection showed a failure to address findings from previous inspections, and visits from the local authority.

The provider had failed to implement effective governance systems to assess and monitor the safety and quality of service being delivered. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● An out of date registration certificate was on display. This did not conspicuously show the conditions which had been imposed on the provider's registration after the last inspection, which is required.
● Training of staff had improved since our last inspection, and the registered manager had implemented a training matrix to provide an oversight of training staff had completed, however, their knowledge was not tested about how the training applied to their practice.
● All of the staff we spoke with told us they enjoyed working at Heronlea Residential Home and felt supported by the management team. One member of staff said, "You can go to [registered manager] or [deputy manager] and they will sort it."
● Both relatives and staff we spoke with described the service as feeling like a family. One relative commented, "It doesn't feel like residents and staff, it feels like one big family."

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
● The provider did not have procedures in place to ensure people's care was planned in a person-centred way. Care records were generic and lacked detail in relation to people's individual needs. We noted some people had care needs which did not have a care plan. Therefore, we were not assured staff had access to adequate information to support people in a person-centred way.
● It was not clear from people's care records what outcomes they wanted to achieve, for example, to maintain contact with their family. This demonstrated a culture which did not prioritise good outcomes for people.
●The lack of assessment of people's capacity, and how they could be supported to make choices meant we were not assured people were included and felt empowered in making decisions about their care.
● People were not supported to maintain their independence. For example, we saw one person was encouraged to sit in a wheelchair to be transferred a few feet when we had observed them walking independently several times.
● We observed there was a lack of interaction with people and provision of meaningful activities. One relative we spoke with explained staff could spend more time engaging people in conversation as their family member would benefit from this.
● People's confidentiality was not maintained. We heard a member of staff discussing a confidential matter relating to a person's current health needs in a communal area.

People's care was not planned in a person-centred way, and the culture of the service was not inclusive or empowering. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

2014.

Working in partnership with others

● The registered manager spoke of having a good working relationship with the GP and the quality monitoring officer from the local authority.

● A GP who provided feedback to us stated the management team called him regularly to discuss any concerns. In addition to this, they conducted a monthly visit to the service, either virtually or in person.