Sheval Limited

Heatherside House Care Centre

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
The service provides care and support for up to 25 younger and older adults with a diagnosis of learning disability and/or autism. Some people also have sensory impairments and/or physical disabilities.

Heatherside House Care Centre is in a secluded location which is geographically isolated. It is a large home, bigger than most domestic style properties. There were 17 people living at the service at the time of the inspection. This is larger than current best practice guidance. People lived together in one large group supported by one staff group. Laundry, cooking and most activities were carried out in communal facilities. The main kitchen was of an industrial style with a serving hatch into the dining room.

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

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 guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
• The model of care and setting did not maximise choice, control and independence. People were not supported to understand and exercise their right to experience the wide range of opportunities that most people take for granted. As a result, the choices they made were limited to a small number of activities they had previously been offered.

Right care:
• People did not receive good quality person-centred care based on best practice guidance. Staffing levels meant people either received support as part of a group or spent substantial parts of the day alone. Plans to improve people's experiences were still based on being part of a group and did not evidence any level of consultation with people living in the service.

Right culture:
• People did not live in a service where the ethos, values and attitudes of the management team and staff enabled them to lead confident, inclusive and empowered lives. The culture of the service focused on the barriers to enabling people to live better lives, rather than on creating the right environment to inspire people to understand and achieve their goals and ambitions. The provider had engaged a consultant and organised for another manager to support the registered manager. However, other than individual actions being added to an action plan based on the previous CQC report; there were no clearly laid out direction or

objectives that the whole staff team understood, fed into and were working towards.

The provider's infection control policy and some infection control practices had been improved.

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 13 January 2021).
At a comprehensive inspection in March 2017, we found ongoing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included breaches of Regulation 12 (Safe care and treatment), 17 (Good governance), 18 (Staffing) and 19 (Fit and proper persons employed). We asked the provider to complete an action plan to show what they would do and by when, to make improvements. We also served a warning notice on the provider and on the registered manager which required improvements to be made, within six months.

In December 2017, we undertook a focussed inspection to check whether the service had addressed the concerns in the warning notices. At this inspection we only looked at the Well-led domain. We found that the requirements of the warning notice had not been met and there was still a breach of Regulation 17. Following the focussed inspection, we met with the provider to discuss how they were going to meet the requirements of the warning notice and improve the service to ensure that they were good in all domains.

At our inspection in August 2018, we found the quality assurance and governance arrangements for the home were still not sufficient to ensure people received safe, effective care. We found breaches of regulation 11 (Consent), 12 (Safe care and treatment), 17 (Good governance) and 18 (Staffing). Following this inspection, the provider submitted an action plan stating how they would make the required improvements. The service was placed in 'special measures'.

In May 2019 we completed a comprehensive inspection and found the provider had not made enough improvements. We found continued breaches of regulations 11 (Consent), 12 (safe care and treatment), 17 (Good governance) and a breach of regulation 9 (Person Centred Care). Following this inspection, the service stayed in special measures and we took action to remove the location from the provider's registration.

At a comprehensive inspection in January 2020 we found the provider had still not made enough improvements. We found continued breaches of regulations 9 (Person Centred Care), 11 (Consent), 12 (safe care and treatment) and 17 (Good governance). We also found breaches of regulations 10 (Dignity and Respect), 13 (Safeguarding service users from abuse and improper treatment) and 18 (Staffing).

At our last inspection in November 2020 we found the service had deteriorated. We found continued breaches of regulations 9 (Person Centred Care), 10 (Dignity and Respect), 11 (Consent), 12 (safe care and treatment), 13 (Safeguarding service users from abuse and improper treatment), 17 (Good governance) and 18 (Staffing). We also found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The service was rated inadequate for the third consecutive inspection. The service has been in Special Measures since November 2018.

At this inspection the information shared with us did not evidence that the provider was no longer in breach of regulations.

Why we inspected
We undertook this targeted inspection to review action the provider told us they had taken to improve the

service. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

CQC have introduced targeted inspections to follow up on, or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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 ongoing evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well-led sections of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heatherside House Care Centre on our website at www.cqc.org.uk.

Enforcement
The service remains in breach in relation to person centred care, dignity and respect, the safe care of people, staffing, consent, and the governance of the service.

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.

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 until we 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?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question where we were told improvements had been made.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question where we were told improvements had been made.

Is the service responsive?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question where we were told improvements had been made.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question where we were told improvements had been made.

Heatherside House Care Centre

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. This was a targeted inspection to review improvements the provider told us they had made to the service.

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 two inspectors.

Service and service type
Heatherside House Care Centre 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. They were being supported by a manager registered to manage another of the provider's services. We have referred to this manager as the 'support manager' throughout the report.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because it was important the registered manager and provider were given sufficient opportunity to prepare evidence of the changes they had made since the last inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We reviewed feedback from the local authority and professionals who work with the service. 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. We used all of this information to plan our inspection.

During the inspection
We are mindful of the impact of the COVID-19 pandemic and took account of the exceptional circumstances when planning the inspection. To reduce the amount of time we spent in the service, we asked the registered manager to identify and provide evidence showing the changes that had been made to the service since our previous inspection. We then requested some further information and records to verify how these changes had been implemented and the impact they had had.
We reviewed this information which included care plan audits, a service user guide, various care plans, meeting minutes, a service action plan and records monitoring the quality of the service. We also spoke with nine people who used the service and five members of staff, including the registered manager, support manager, senior care workers, care workers and the activities co-ordinator.

After the inspection
We continued to seek clarification from the provider to validate evidence found and spoke with a professional who knows the service.

Inspected but not rated

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. We have not changed the rating of this key question, as we only looked at the section of the key question where the registered manager told us they had made improvements. The purpose of this inspection was to check if the provider had met the requirements of the regulations or had made improvements. The evidence we were shown at this inspection did not evidence the regulations were now met or that significant improvements had been made. We will assess all of the key question at the next comprehensive inspection of the service.

Staffing and recruitment

At our last inspection the provider had failed to adequately assess the level of staffing required in the service. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were shown the staff dependency tool, used to calculate staffing levels in the service, and the rota. The dependency tool still showed people were allocated an inadequate level of staff time for their needs. Ten of seventeen people living in the service were allocated less than two hours staff time over a 24-hour period for all their support and care needs. This is a comparable level to people living almost independent lives in the community. This was not enough to ensure people received person centred care in line with their needs.
● The rota showed staffing levels had not changed since the last inspection; four or five staff were on duty during the day and two or three staff during the evenings. When people sought engagement from staff members, it was not always possible for them to respond, due to the low staffing levels. This had not changed from previous inspections. We observed several people disengaged throughout the day or waiting for staff support. We observed one person standing for some time in a corridor waiting for staff support and another person walking round the service calling for a specific staff member. They were told the particular staff member they were looking for was busy; they were not offered support by anyone else. We noted several other people still spent most of their days alone in their rooms and one person was sitting in the dining room waiting at 4pm, even though their evening meal was not until 5pm. These observations showed people were still not meaningfully engaged throughout their day.
● Staff were being recruited to work in the evenings but the capacity of the staff team to provide person centred support during the day had not been increased.
The provider had failed to ensure sufficient staffing levels to meet the needs and preferences of the people living in the service. This is an ongoing breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our last inspection we raised concerns about the provider's recruitment processes. At this inspection we found not enough improvement had been made. We were shown the recruitment file of a new staff member. The staff member's application form only detailed the years the staff member had worked in previous jobs. It did not detail the months they had started and stopped working in the jobs listed. Concerns

about the information recorded during staff recruitment had been raised at the last inspection and at previous inspections. This showed lessons had not been learned to ensure safe recruitment practices were followed.

This formed part of an ongoing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last comprehensive inspection, the provider had not ensured current infection control guidance was being adhered to. We requested an action plan showing how they would make the required improvements. A follow up inspection to check on infection, prevention and control found no further concerns. However, at this inspection we found areas requiring improvement.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We were shown records of cleaning completed by staff of high contact areas, such as door handles and light switches, after domestic staff had finished at 3pm. However, these did not include high contact points in a communal bathroom, the staff toilet, the staff sleep in room where all staff left their belongings throughout their shift, the entrance lobby or hallways. This increased the risk of cross infection. This action had been marked as met on the action plan created by the provider's consultant.
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. However, the policy and risk assessment to admit visitors had not been reviewed to ensure it reflected recent government guidance.

The provider had not taken all necessary action to protect people from infection. This formed part of an ongoing 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.
● The provider was not currently admitting anyone 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 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.

Assessing risk, safety monitoring and management

At our last inspection the provider had not ensured people were supported to take positive risks to increase their experiences and improve their lives. This formed part of a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements were still required.

● A consultant engaged by the service had created an action plan which noted the action, "'Involve me' and positive behaviour support training will be used to support the service users to identify new experiences. These will then be risk assessed starting with the identification of potential benefits", as completed. However, we continued to find examples of people's lives being limited due to the staff approach to risk.
● People were still not supported with the least restrictive option available. One person living at the service

particularly enjoyed shopping for their own food. Their social worker told us that due to current restrictions, the person had been told they could no longer do their own food shopping, even though they understood good infection control practice. The registered manager confirmed staff now went to the shop to get the person's food shopping for them. The person had not been supported to complete their shopping online and collect it from the shop. This would have reduced the risk but still maintained a level of independence and increased their wellbeing.

● Their social worker also told us they had had to explain to the person that they were able to go out alone to exercise. The person had raised concerns about the safety of walking down a busy main road at the front of the property, as they didn't know there was a gate at the back of the property they could use. The person had been living in the service for several months without staff providing them with the required support to remove the restrictions they were experiencing. This showed that despite training, the principles of Right support, right care, right culture were not understood in the service.

● At the last inspection we raised concerns that one person was not allowed to access the kitchen. The action plan now created by the provider's consultant noted that no person would be prevented from going into the kitchen, but a risk assessment would be put in place. Following the inspection, the registered manager confirmed the person's original risk assessment that "discouraged access" to the kitchen was still in place. This highlighted a lack of skill within the staff team to support the person to use the kitchen safely and reduce the restrictions placed on them.

The provider had not ensured people were enabled to take positive risks. This formed part of an ongoing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the behaviour of the provider's director exposed one person to improper treatment. 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.

We did not witness any improper treatment during the inspection. The provider is no longer in breach of this regulation.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we only looked at the section of the key question where the registered manager told us they had made improvements. The purpose of this inspection was to check if the provider had met the requirements of the regulations or had made improvements. The evidence we were shown at this inspection did show some additional training had been provided, however the service remained in breach of the regulations. We will assess all of the key question at the next comprehensive inspection of the service.

Staff support: induction, training, skills and experience

At the last inspection we found the provider had not ensured staff had the correct skills and knowledge to meet people's needs. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements were still required.

● We were shown the training matrix which evidenced staff had completed further training since the last inspection. This included food hygiene, food safety, infection control, safeguarding and person-centred approaches, for those staff whose training had not been up to date at the last inspection. Staff had also completed positive behaviour support training.
● While some staff told us they had reflected on different aspects of the training, they could not give us examples of how it had changed their practice, or practice within the service. They were not being effectively supported to work together as a team to drive the improvements required to make a positive impact on people's lives. Some staff members confirmed some of the training had made them think differently, however, no-one was able to tell us what systems were in place to ensure this new knowledge became embedded in the everyday culture of the service. This meant each individual staff member was working in a different way based on what the learning had meant to them. One staff member confirmed no-one had used the positive behaviour support training to update or improve people's positive behaviour support plans.
● We were shown staff meeting minutes. These showed several missed opportunities to encourage discussion about how staff could improve the way they supported people. People's behaviour was mentioned, but there was no discussion recorded between staff members regarding what worked or didn't work well when supporting people. A staff member queried whether each person needed a keyworker as they believed this made some people anxious. Minutes recorded that the provider responded, "Yes, CQC prefer them to." This showed a lack of understanding of the regulations and also of a person-centred approach. Another staff member queried whether resident's meetings should be held less frequently as, "Although given options to discuss different things there was no real feedback." No discussion about how staff could enable people to contribute more fully to the resident's meetings was recorded.

The provider had not ensured staff had the correct skills and experience to improve the outcomes

experienced by people living in the service. This contributed to an ongoing breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support

At the last inspection we found the provider had not ensured staff had all necessary information to reduce risks relating to people's health needs. This formed part of a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements were still required.

● We were shown three people's oral care plans. However, these still focused on what people wouldn't do. For example, "Staff encourage me to use mouthwash, but I do not like the taste and often choose not to use it. I do not like visiting the dentist and so far, have declined" and "Staff should continue to try and get me to engage in oral care but respect my choice if I decline." They still contained no detail of specific steps staff should take to try to engage people in looking after their oral health. This put them at risk of poor or declining oral health. This had not been identified during care plan audits or in the action plan created by the provider's consultant.

The provider had not ensured staff had the correct information to mitigate risks to people. This contributed to an ongoing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Two of the care plans we were given were almost identical in wording. This showed a lack of personalisation in people's records.
● We were shown a letter confirming that one person, whose support with their oral care we had previously raised concerns about, was now on a waiting list for a dental check-up.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection the provider had not ensured they had complied with the Mental Capacity Act 2005 (MCA). This was a continued breach of regulation 11 (Consent).

At this inspection, we were shown the service's action plan. It stated an action, to audit care plans and individual MCA assessments for each specific area and complete best interests' decisions if necessary, was completed. However, we were not provided with any evidence of this during the inspection, so this regulation was not reviewed.

Inspected but not rated

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we only looked at the section of the key question where the registered manager told us they had made improvements. The purpose of this inspection was to check if the provider had met the requirements of the regulations or had made improvements. The evidence we were shown at this inspection did not evidence these regulations were now met or that significant improvements had been made. We will assess all of the key question at the next comprehensive inspection of the service.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to ensure people's needs and preferences were met in a way that maximised the choice and control they had over their life. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 9.

● There was still little evidence of people having true choice and control over their lives. At the last inspection we spoke to one person who wanted to buy an electric razor to increase their independence. When we arrived at the inspection, the person asked us if we thought they needed to shave. They confirmed that they still wanted to buy an electric razor but had not been supported to do so yet. This increased their reliance on staff and reduced their opportunities to be independent. Following the inspection, the registered manager stated the person's care plan had been updated since the inspection to say the person no longer wanted a new razor.
● Choices and options for people during the day, were still group based with little opportunity for people to be supported with individual goals or pastimes. There was little evidence of people living individual lives; there was a group menu for meals, a group activity timetable and group facilities.
● The staffing dependency tool showed no-one was allocated more than 40 minutes of staff time over 24 hours for "communication/prompting/social and emotional." Taking into account the needs of the people in the service and the service's location, this was inadequate. Ten people were allocated 20 minutes staff support, or less over a 24-hour period for this area of their lives. The provider's understanding of the level of support people in the service needed to live similar lives to any other citizen had not improved.
● Care plans had not been updated to include the level of detail staff would need in order to provide tailored, person centred support. We were shown one person's 'level of understanding' care plan. It still did not describe in which areas of their life their understanding was good or where they needed support. It still described them as 'mute' which is not a respectful term, and we have previously raised concerns about this. We were also shown the person's communication care plan. It still failed to provide specific information to staff on how to communicate effectively with the person. The person's level of skill was accepted as unalterable and no recent effort had been made to record small pieces of communication or understanding, to aid future interactions. This meant the person's ability to express their views was severely limited and

reflected the low expectations staff had for them.
● We were shown a care plan for someone who had been diagnosed with mild schizophrenia and bipolar disorder. It stated, "Support […] to have a focus and provide a routine, which may be important to her" and "Talk to […] about doing regular exercise and planning activities she enjoys that give her a sense of achievement." It lacked detail of the specific support the person needed in these areas, which meant there was no clear understanding in the staff team about the best way to support, encourage or motivate them.
● The staff team understood people had the right not to engage in the activities being offered; however, they did not recognise this as an opportunity to work with people to expand their knowledge of what else was available to them. There was little effort to identify creative or engaging approaches to motivate and support people to develop individualised interests or pastimes. Due to restrictions related to the pandemic, some of the things this person had enjoyed doing previously had stopped. A staff member confirmed the person now mainly stayed in their room, adding, "It's difficult to get […] to engage." They could not describe what routine or focus the person had, or how they were supporting the person to feel a sense of achievement, even thought this was a requirement of the person's care plan. They told us they thought routine for the person was about the day being predictable. This had impacted on both the person's independent living skills and their quality of life.
● The person's care plan stated, "Eating well and keeping fit can help reduce the symptoms of bipolar disorder." A staff member told us, "It's difficult to support them with diet, it's a hard one, food is a choice." However, when we asked the person if they had enjoyed their lunch, they told us they didn't really like it as it was chicken and they didn't like meat apart from mince. An "all about me" overview of their preferences noted, "I am not a big fan of meat", but this information had not been included in their nutrition and hydration care plan. The local shop the person had enjoyed visiting regularly had closed. Their care plan had not been updated to reflect this change or any discussion of alternatives that might encourage the person to exercise regularly.
● Staff had recognised that the person's wellbeing was being affected. As a result, the person had been referred to the mental health team. This showed a failure to identify, understand and deliver people's care and support needs in a way that helped them maintain their health and wellbeing.

The provider had failed to ensure people's support was designed to meet their individual choices and preferences. This forms part of a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our last inspection the provider had failed to ensure staff identified and met people's preferences. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection improvements were still required.

● There had been very little change in how people were supported to identify things that interested them, or in how they spent their time. Some people told us of individual activities they had enjoyed but a timetable of group activities remained in place and staff confirmed there had been no planned approach to supporting people individually to develop plans, goals or aspirations based on their interests and passions or how their support could be tailored to enable them to live the life they wanted.
● Staff were not skilled in sharing and using information they knew about people to develop and trial new opportunities. Information staff members were aware of about individual's wishes had not been shared across the team. Staff told us people were consulted about what they wanted to do, however, some people still lacked the support to communicate their views, and the choices made were still based on a limited

number of options people had prior experience of. Timetabled activities available the week of the inspection were unspecified 1:1 activities, baking cheese scones, planting seeds and a darts and coffee morning. This did not evidence a variety of choices for 17 people and did not reflect the choices and opportunities other citizens take for granted. A poster displaying charges for entertainment, bingo and cooking was still on display in the service. Two people, when asked told us they had no plans for the day.
● Staff members were not proactive in encouraging, motivating or enabling people to engage in new or different things. Staff still focused on the barriers to engaging people. The same people we observed as spending most of their time alone in their room at previous inspections, continued to do this. One staff member confirmed, "There is a tendency for the afternoons to have nothing. It's easy for staff to think that people have done something in the morning so there is no need in the afternoon. If there's nothing on offer, people won't tend to do anything. Staff need to be proactive in encouraging people to do things."

The provider had failed to enable people to understand all choices available to them, be involved in designing their care and ensure their preferences were met. This forms part of a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, the provider had not ensured service users were supported to develop or maintain autonomy, or involvement in the community. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection improvements were still required.

● There was an ongoing resistance to engaging with the local community, a lack of understanding of the provision of person-centred care and low expectations for people. These pointed towards a closed culture.
● Despite the restrictions related to the pandemic, there remained ways people could use the local community. However, plans highlighted by the provider, showed an intention to increase the number of opportunities within the grounds of the service. These included creating a nature walk, a cycle track, a putting green and a pub in an outbuilding. Pandemic related restrictions were due to be reduced and the service was on Dartmoor, close to many pubs, walks, golf courses and traffic free cycle routes. The plans of the provider to increase the opportunities within the grounds of the service would have provided further reasons for people to remain at the service instead of using the local environment in the same way as other citizens. This approach was indicative of the provider's ethos of keeping people separate and apart from the wider community.

The provider had failed to ensure people had the support they needed to maintain their autonomy and independence. This contributed to an ongoing breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● One person was now receiving end of life care. Despite the staff knowing the person and their preferences well, their end of life preferences care plan gave little indication of what staff could do to make the person as happy as possible. The care plan stated staff were to make the person feel "safe, comfortable and valued in the final stages of her life" but gave no detail about how to achieve this for the person.

This contributed to an ongoing breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

At our last inspection we found the provider had not ensured people were always treated with dignity and respect and their independence was not supported. This was a continued breach of regulation 10 (Dignity and Respect). At this inspection, we found some improvements were still required.

● We were shown three records of people showing behaviour that challenged staff. These incidents had been reviewed but areas for improvement had not been identified. Language such as, "stormed off to his room" and "roaring" had not been highlighted in records of staff debrief sessions as areas where staff needed to improve.
● We were shown a dignity and respect audit completed by the registered manager, this had focused on recording purely positive information and therefore had not been used effectively to identify and make improvements. For example, the audit asked about people's independence and autonomy. People were still not supported to independently plan how they would like to spend their day or week, they were not routinely encouraged to cook their own meals, wash up, or take part in cleaning tasks. None of these had been noted on the audit.
● Despite staff suggesting during a team meeting that the support the person received to maintain their independence could be increased, no further discussions followed. The registered manager instead told staff they were doing all they could to promote the person's independence.

The provider had not ensured staff promoted people's dignity and respect and independence, at all times. This contributed to an ongoing breach of regulation 10 (Dignity and Respect).

Inspected but not rated

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. We have not changed the rating of this key question, as we only looked at the part of the key question where the registered manager told us they had made improvements. The purpose of this inspection was to check if the provider had met the requirements of the regulations. The evidence we were shown at this inspection did not evidence these regulations were now met. We will assess all of the key question at the next comprehensive inspection of the service.

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

At our last inspection the provider had failed to ensure people were supported to achieve good outcomes by staff who understood and implemented best practice. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvements were still required at this inspection.

● The culture of the service and people's outcomes had not improved. An action plan created by the service's consultant stated, "Provider and manager have read RSRCRC and are developing strategies both operationally and practically about how they can develop the service within the guidance." Despite asking for evidence of changes made to improve the service, we were not provided with these strategies. Observations in the service showed the ethos of Right support, right care, right culture (RSRCRC) was not fully understood or embedded in the service.
● People still lived as part of a group rather than living their life in a way any other citizen would expect to live. The action plan developed by the consultant, highlighted throughout, an aim to separate people into smaller groups within the service. It commented, "Staff will be given a group of service users and they will support the same people throughout the day." This showed a lack of respect in the way people were described and reflected culture in the home that failed to see individuals rather than groups. It also evidenced a lack of understanding of the Right support, right care, right culture principles and of how to support people to live as independently as possible. We were shown staff meeting minutes which also described working in smaller groups with people as a way to reduce the feeling of institutionalisation. Staff were told they should consider the most appropriate small groups for staff to work with and the senior on duty each day would allocate staff to a group of residents who they would be responsible for that day. This was another example of people being 'done to'. The plan was vague and there was no indication people had been consulted about this or involved in how the groups might be organised. There was no direction that staff should discuss with people if they would like to spend the day alongside others or do similar things.
● People were still referred to by staff and in care plans in terms of what they couldn't or wouldn't do, and there was very little effort made to capture and share things that helped people accept support and improve their skills. Instead, refusals to take part in things were seen as respecting people's choices. This had led to people losing motivation to get involved in many activities. A staff member told us they thought a lack of

motivation in the manager had led to a lack of motivation in the staff team and then in people that lived in the service.
● Restrictions were still placed on people rather than support to enable them to overcome difficulties. For example, one communal toilet had a keypad on it and was not accessible to people living in the service. The registered manager told us it was locked as it was the staff toilet and one or two people sometimes put paper towels down the toilet in there. Both people had constant access to en-suite toilets and a further communal bathroom that did not have keypad locks on them. The registered manager did not have a clear idea of why the people occasionally put paper towels in toilets and everyone had been restricted from using the toilet, rather than the people being supported to change their behaviour.

The provider had not ensured the service was aligned with current best practice. This reduced the quality of people's lives. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider had failed to enable all people to influence how their service was provided. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvements were still required at this inspection.

● The culture of the service was still one of group living and 'one size fits all', with little consultation of people's views. People had still not been fully engaged with changes to the service and we were shown no evidence to show any changes were based on their preferences, or that they would benefit from them. Medicines cabinets had been put in everyone's rooms, the frequency of resident's meetings had been changed, staff had been instructed to support small groups of people and new staff had been recruited. All without any true consultation or involvement of people in these decisions.
●Furthermore, the action plan drawn up by the service's consultant noted about the future layout of the building, "When the plans have officially been drawn up, the manager and owner will hold a consultation meeting with the residents and families." We were not shown any evidence of any work undertaken to support people to understand, consider and feed in their views about different options for changes to the layout of the building. People had not been included in or empowered to influence the plans before they were drawn up.
●An extension to the existing building was still in progress. Part of an external wall had been demolished, just outside one person's bedroom to link the extension to the existing service. The hole in the wall had then been covered by wooden boards only. No-one was able to confirm what the extension was for and we were provided with no evidence that people or their advocates had been consulted about these changes.

The provider had not sought feedback from people before planning or implementing changes within the service. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had suggested people might be able to write their own daily notes and it was agreed in a team meeting, this could be discussed with each individual.

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

At our last inspection the provider had failed to ensure the quality and safety of the service had been adequately assessed, monitored or improved to ensure it met with regulatory requirements. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvements were still required at this inspection.

● Extra support engaged by the provider to improve the service had not resulted in the required changes. Since the last inspection, the provider told us they had engaged a consultant to work with the service for three days a week over the course of three weeks. In addition, a registered manager from one of the provider's other services (a domiciliary care agency) was supporting the registered manager of Heatherside House to make the required improvements. The support manager told us they were working at Heatherside House two to three days per week.
● Although our previous inspection was in November 2020, the support manager had not been brought in to support the registered manager until February 2021. This indicated a lack of commitment by the provider to make the necessary changes, and a lack of understanding of the level of change required. The support manager told us they had managed a learning disability service in, approximately, 2003 and were familiar with the Right support, right care, right culture guidance. The service improvement action plan stated the support manager, "will be concentrating on service users' involvement and upskilling the staff to provide person centred care." However, they had failed to identify some of the key failings regarding the existing model and culture of the service. They had recognised people received little staff engagement in the afternoon but told us no action had been taken to move away from timetabled, morning activities and had not raised concerns about the aim to allocate small groups of people to each staff member every day. They confirmed to us that they would need to update their knowledge and understanding of the needs of people with a learning disability.
● An action plan had been created by the consultant, however there was no consistent understanding by staff at all levels of what changes were needed in the service, how these would be achieved and what each staff member's role was. One staff member told us about some activities they thought some people would like to do in the future, however, when asked they said they didn't know how these things could be achieved with current staffing levels. In our conversations with the support manager, they frequently told us they 'believed' things were in place or were going to be done. When we asked them what the priorities were for improving the service, they told us it was not very dynamic and that they had completed some care pans audits and completed a new service user guide. They did not have a clear vision for how the service would improve or what the priorities were.

The provider had not implemented sufficient change to meet the regulations or reflect best practice. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

At our last inspection the provider's governance systems had not resulted in improvements to the service people received. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection improvements were still required.

● Governance systems were still not being used effectively in the service to identify areas that needed improving. The registered manager completed daily records of things that were happening in the service. The records showed the registered manager engaging with people on a superficial level, asking if they were ok and discussing TV programmes. They did not evidence real engagement that would lead to a better understanding of what improvements were needed in the service. The records also noted each day what activities were on offer but did not note any actions to improve this area of the service. Some small minor

improvements were highlighted but they did not evidence that the registered manager saw or understood the level of change required in order to enable people to live fulfilling lives.
● The registered manager confirmed they still did not have a means to review or oversee the opportunities available to people in the service each day, how many people engaged with different activities and who mostly declined. This ongoing lack of action meant people's opportunities to engage in meaningful pastimes and try new experiences remained limited.
● We were shown some recently completed audits of care plans. These identified some areas for improvement, but not all questions prompted by the audit had been answered accurately enough to identify all the improvements required.
● We were told the number of incidents of behaviour that challenges had reduced. However, improvements to how people were supported were not always sought. A debrief with a member of staff identified that the strategies tried had not worked but then concluded, "[Staff member] will continue to use strategies in place." There was no discussion about alternatives that may result in a more positive outcome for the person.
● The service's consultant had produced a plan of improvement actions, noting which had been completed. However, this did not show a completely accurate picture of the service, documentary evidence of completed actions, or detail about how the individual actions contributed to improving people's experiences.
● The action plan recorded on 1 February 2021 that PRN protocols had been written for all 'as required' (PRN) medication. However, a separate service improvement plan in the service, showed that a later audit of medicines administration records (MARs) found some PRN protocols were missing. It also stated that an action to improve people's oral hygiene care plans was met. However, the oral hygiene care plans we were shown still did not contain sufficient detail to ensure staff knew how to meet people's needs.
● The same action plan stated the home was being supported by a manager who was experienced in running a residential home for people with learning disabilities. This was not the case. The support manager confirmed to us they had managed one small learning disability service in, approximately 2003.
● We were shown a service improvement plan. This showed that a recent medicines audit had identified several issues with medicines management. Some of these had been raised at the last inspection and showed insufficient improvement had been made.

The provider's governance systems were still ineffective in improving the service people received. This was part of a continued breach of continued Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulation 18 Registration Regulations 2009
At the last inspection, the registered manager had failed to notify us of an injury sustained by a person living in the service as required by their registration. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We were not provided with any evidence relating to this regulation during the inspection, so it was not reviewed. However, we are not aware of any notifiable incidents the provider has failed to inform us of. Therefore, they are no longer in breach of this regulation.