Heathfield Healthcare Limited

Heathfield Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Heathfield Residential Home is a care home which was providing personal and nursing care to 19 people aged 65 and over at the time of the inspection. The service can support up to 35 people in one adapted building.

People's experience of using this service and what we found
Few improvements had been made since the last inspection. There continued to be many shortfalls in the service provided to people.

Individual risks were not always assessed and managed to keep people safe. People could not be sure their prescribed medicines were always managed in a safe way. When people had accidents and incidents, action was not always taken to learn lessons to reduce the risk of a re-occurrence.

People could not be assured new staff were asked to provide the robust information needed to make sure they were suitable for their role providing care and support to people.

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.

Although people had an assessment of their care needs before moving into the service, this did not always capture the important detail needed to develop an individual care plan to ensure their safety.

People could not be assured there were enough staff on duty at night to make sure they could be evacuated safely if an emergency such as a fire took place. We have made a recommendation about this.

Although staff training had improved, there were still areas for concern where people may not have skilled staff on duty to provide their care.

Infection control practice in relation to the latest COVID-19 government guidance for the use of PPE in care homes was not always followed to keep people and staff safe.

People who needed their food and fluids monitored could not be sure this was happening consistently or that areas of concern were noticed. Timely referrals to healthcare professionals were sometimes not made to make sure people were not in discomfort.

The management and oversight of the service was still not robust enough to identify areas of concern and put actions in place to continuously improve quality and safety. Only few improvements had been made since the last inspection and this was a cause for concern. This was the fourth inspection where the provider

had not achieved a rating of good and the second consecutive rating of inadequate.

Staff had regular individual support meetings and the registered manager held regular staff meetings to keep staff up to date.

The registered manager now made sure they alerted the appropriate authorities if there were allegations of abuse.

The service was clean, pleasant and well maintained. People's individual rooms had personal items and furnishings to help them to feel at home. The provider asked for and listened to people's views, and their relatives.

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 10 April 2020) and there were multiple breaches of regulation. We served a Notice of Decision to impose conditions on the provider's registration for this location. This included requiring the provider to update CQC on improvements made through monthly reporting and to keep CQC informed of any admissions to the service with assurances of their ability to provide people's care.

At this inspection insufficient improvement had been made and the provider was still in breach of regulations.

Why we inspected
We received concerns about staffing levels and safeguarding concerns in relation to people leaving the service unaccompanied when not safe to do so. As a result, we undertook a focused inspection to review the key questions of safe, effective 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 the previous comprehensive inspection for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe, effective and well led sections of this full report.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of their 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well led. Details are in our well led findings below.	**Inadequate**

Heathfield 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 Care Act 2014.

Inspection team
The inspection was carried out by three inspectors. Two inspectors visited the service and a third inspector collected and reviewed information we asked the provider to send us by email during the inspection.

Service and service type
Heathfield Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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 announced. We gave the provider less than 24 hours' notice of the inspection. This was to check if any staff or people at the service had tested positive or had symptoms of COVID-19 and to discuss arrangements for the inspection and PPE required.

What we did before the inspection
We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are

required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. The registered manager engaged in an Emergency Support Framework (ESF) call with a CQC inspector prior to the inspection. This is a supportive conversation CQC has held with providers or registered managers of all services during the COVID-19 pandemic crisis to check how they were managing. We used all this information to plan our inspection.

We asked the provider to send a range of documents by email to support the inspection when we made contact to announce the inspection. This enabled inspectors to spend less time in the service, to support restrictions to reduce infection during the COVID-19 crisis.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with eight members of staff including the registered manager, the deputy manager, the area manager, care workers and housekeeping staff.

We reviewed a range of records. This included five people's care records, as well as the records of one person who had recently left the service, and many medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service including monitoring and auditing records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed a range of documentary evidence including training records, staff meetings, residents and relatives' meetings and auditing and monitoring documents.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to ensure that risks to people were assessed and that they were doing all that is reasonably practicable to mitigate risks. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There was insufficient improvement at this inspection and the provider was still in breach of Regulation 12.

- Risk assessments were still not detailed enough to guide staff how to reduce risks and keep people safe. Some people had a history of epileptic seizures and were prescribed medicine to prevent them. However, a person, who moved in to the service in June 2020 did not have an epilepsy care plan or risk assessment in place.
- Another person who had a history of epilepsy did have a care plan in place and a risk assessment providing standard, rather than individual, information. Not all staff had completed epilepsy training so some may not have the basic awareness of how people were affected individually. The person was described as previously having shown signs of 'vacant absences'. They had a number of unwitnessed falls, but consideration had not been given to whether seizures were a factor in them falling.
- Some people's care records referred to hourly checks by staff when they were not in the communal areas. This was to maintain people's safety. There was limited evidence that these checks had been consistently carried out. Hourly checks were only recorded twice during June and July 2020 for one person. This increased the risk of people not consistently receiving the support they needed to stay safe.
- Individual risks from people's health conditions like low blood pressure or osteoporosis had not always been assessed and a plan in place to reduce the risk of harm. People were at increased risk of deteriorating health as specific signs and symptoms were not always detailed.
- Not all staff working in the service were wearing the type of face masks as set out in Public Health England's 'Personal protective equipment (PPE) – resource for care workers working in care homes during sustained COVID-19 transmission in England' July 2020. Some staff were wearing reusable face masks within the communal areas of the service, rather than surgical masks as recommended. The recommended face masks are to safeguard people living in the service and staff. This put staff and people at a higher level of risk of contracting COVID-19.
- At the last inspection, fire evacuation drills had not been undertaken. The registered manager now held regular drills with staff. However, learning from the evacuation drill was not recorded in order to improve the effectiveness of the fire procedure and make sure all staff knew and practiced their responsibilities in the event of a fire.
- Each person had a Personal Emergency Evacuation Plan (PEEP) to provide information about the assistance they would need to reach a place of safety during an emergency. PEEPs did not identify specific

individual risks and challenges. For example, some people used paraffin-based emollients on their skin, which could increase risk of burns and injury in the event of a fire. PEEPs did not always detail which equipment such as fire evacuation chairs were required to get people down the stairs safely. Plans were not sufficient to support people to safely evacuate.

Using medicines safely

● Medicines administration within the service was not managed safely. Medicines administration records (MAR) showed most people had received their medicines as prescribed. However, stocks sometimes ran low or did not tally. One person did not receive pain relief one day as the stock of their medicine had ran out. They reported to us during the inspection they were in pain and their daily records evidenced they were living with chronic pain. The MAR also showed another date when the person had not been given their medicine.

● Three people had run out of medicines and had to go without pain relief and other medicines which they had been prescribed. By the end of the inspection, all out of stock medicines had been obtained for the people that had missed their medicines. The provider and registered manager assured us they would review their medicines monitoring processes.

● One person was prescribed a medicated pain patch every 72 hours. Records showed the pain patch had not been administered as directed with long gaps between applications on two occasions. The person's daily records evidenced that they were in consistent pain during this period. Their care records evidenced that staff had reported unmanaged pain to healthcare professionals. Records for two peoples' pain patches did not always show the pain patch had been re-sited in accordance with the manufacturer's guidance to avoid skin irritation.

● Medicines were not always kept at the correct temperatures to maintain their efficiency and action was not always taken to reduce the temperature to below the maximum levels recommended. Staff had raised concerns about the air conditioning unit in the medicines room, but this had not been addressed at the time of the inspection.

● Most people were prescribed 'as and when required' (PRN) medicines. PRN protocols detailed how people communicated pain, why they needed the medicine and maximum dosages. One person used a spray prescribed for angina and they did not have a PRN protocol in place. Another person did not have PRN protocols for two of their prescribed medicines. This meant that staff may not have all the information they needed to identify why each person took their particular medicine and when they might need it.

● The registered manager was not following the provider's medicines policy about self-administration of medicines. The medicines policies for the service did not reference or link to good practice guidance and information such as the Royal Pharmaceutical Society guidance on handling medicines in social care or NICE (The National Institute for Health and Care Excellence) 'managing medicines in care homes' guidance.

Learning lessons when things go wrong

● At the last inspection, the provider did not have robust processes in place to appropriately respond to incidents. Opportunities to learn lessons had been missed. At this inspection, the response to accidents and incidents had not improved.

● One person's care records showed they actively walked around the service and tried to leave on their own when it may not be safe for them to do so. Their records advised staff should try and distract them, however, they would continue to try to leave. There was no further information for staff as to how they could work with the person to reduce the risk of them leaving the service. The provider and registered manager had not reviewed the staffing allocation to support the increased monitoring of the person's whereabouts. The person did leave the building while staff were busy with other tasks and checks of the person's whereabouts had not been undertaken. The person had been gone two hours before staff noticed they were missing.

● Incidents where people were acting in a way that may harm themselves or others were not always

appropriately recorded, analysed or acted upon. Plans were not in place to prevent a re-occurrence. Where people had attempted to climb out of windows, timely action had not been taken to review window security to ensure people were safe from the risk of falling. We found a downstairs window fully open during the inspection with ineffective security to maintain safety. The provider had arranged for this to be rectified and the window made safe during the inspection. They said they would have all windows checked immediately.
● Two people had many falls over the previous three months, and it was not clear what action had been taken to prevent further incidents. Although one person had been referred to a falls clinic, and they were waiting for an appointment, they continued to fall repeatedly. There was no evidence that further action had been taken to keep people safe while waiting for healthcare professional advice when people continued to fall.

The failure to provide safe care and treatment by reducing risks to people's health and safety is a continuing breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● The property was well maintained and all appropriate servicing had been completed within the correct timescales. These included, fire alarm system and equipment, gas safety, electrical safety and legionella risks. Equipment such as hoists, bath chairs and the passenger lift had been checked.

Staffing and recruitment

At our last inspection the provider had not completed the appropriate checks to ensure that staff were recruited safely in to the service. This was a breach of Regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of Regulation 19.

● The safe recruitment of staff had not improved since the last inspection. Two recruitment files for staff who had been employed since the last inspection showed similar issues as those we found at the previous inspection. There were gaps in employment histories, anomalies in dates of staff previous employment and references which had not been verified in any way.
● The inaccurate records had not been discussed and verified by the provider or registered manager before employing the staff members.
● The provider and registered manager could not be assured the staff they had employed were suitable to work with people living at the service who needed personal care and support.

The failure to ensure staff were recruited safely in to the service by completing the appropriate checks is a continuing breach of Regulation 19 (Fit and Proper Persons Employed) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other pre-employment checks had been undertaken. For example, Disclosure and Barring service (DBS) checks had been completed which helped prevent unsuitable staff from working with people who could be vulnerable.

At our last inspection the provider had failed to make sure there were sufficient numbers of staff to support people. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found that the staffing numbers deployed during the day had improved. However, there remained areas for improvement with night staff deployment.

● There were suitable numbers of staff to support people through the day time. However, the staffing rota showed that there were not enough staff allocated on shift at night to be able to safely evacuate people in an emergency. One person's PEEP showed that they lived with dementia and required one member of staff to stay with them. There were only two staff on shift at night which meant that only one staff member would be available to evacuate the other people. Another person's PEEP said staff may need to use a slide sheet. This would require two members of staff.
● Assessments of staffing levels were undertaken by the registered manager using a dependency tool. However, the tool calculated how many staffing hours were required across a 24-hour period. It did not calculate the numbers of staffing needed at night, taking into account fire risks.

We recommend the provider and registered manager seek appropriate advice with a view to review safe staffing levels across the 24-hour period.

● People were happy and relaxed and call bells were answered promptly during the inspection. One person told us, "The staff are nice and friendly and come quickly when called. I try not to call the call bell at night too often but know I can if needed." We did not hear anyone calling out, needing assistance and not receiving it, during this inspection. This was a clear improvement since the last inspection.
● Staff said they thought they had enough staff to meet people's care needs. They were pleased agency staff were no longer required, due to appropriate staffing levels, as they felt it was beneficial to people to have staff who knew them well providing their support day to day.

Preventing and controlling infection
● The provider had put in place a 'no visitor' policy inside the service to protect people and staff from the risks of contracting COVID-19. There was clear signage on the outside of the front door about this. Essential visitors were provided with single use surgical face masks if needed. There was guidance around the service reminding people to be no closer than two metres apart. However, people's armchairs were not spaced at this distance apart in the service to enable people to respect this.
● At the last inspection, only 12% of staff had completed infection control training. We highlighted this as an area that needed to improve. At this inspection, most staff had now completed this training.
● The service was clean, tidy and smelled fresh. Additional cleaning took place to decrease the risks of contracting and transmission of COVID-19. We observed this happening. PPE was well stocked and placed at regular intervals through the service for ease of use by staff.
● People living at the service and staff had received regular COVID-19 tests. Temperature checks were carried out regularly to monitor symptoms of COVID-19 to reduce the risks of transmission.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to operate effective systems and processes to investigate and immediately act upon any allegations of abuse. This was a breach of Regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection, improvements had been made and the provider was no longer in breach of Regulation 13.

● At the last inspection, the provider had not made safeguarding referrals to the local authority. People had

left the service unaccompanied and without the provider's knowledge and this had not been reported to appropriate authorities. At this inspection, although people had again left the service unaccompanied when it was not safe for them to do so, the local authority safeguarding team had been alerted.

● At the last inspection, people had been restricted from going out, without the appropriate legal authority to deprive them of their liberty. At this inspection, the provider and registered manager had made Deprivation of Liberty Safeguards (DoLS) applications.

● Staff had now received safeguarding vulnerable adults training. Staff had confidence in the management team and provider to appropriately deal with concerns. One staff member said, "I would report any abuse to [registered manager], who would start an investigation and take statements. We would report to social services, the area manager and CQC too."

Requires Improvement

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 inadequate. At this inspection this key question has now improved to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
At our last inspection the provider had failed to ensure that care and treatment of people was only provided with the consent of the relevant person. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and the provider was still in breach of Regulation 11.

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 Act 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- A clear understanding of the MCA was not evidenced in people's care records. Care plans around choice and consent were confused and gave conflicting information. The electronic care plan recording system populated records with standard text. This meant people's individual information and how they were able to make choices was not always clear.
- There was conflicting information in some people's care records about their capacity to make their own decisions, and MCA assessments had not always been carried out when appropriate. Similarly, appropriate DoLS applications had not been made when people's liberty was restricted; this may have been a breach of their rights.
- One person had repeatedly tried to leave the service. Their records showed that a DoLS authorisation was applied for and awaiting a response. The provider and registered manager had not applied for an urgent DoLS for the person even though the person was already being deprived of their liberty because they were

trying to leave the service and were being prevented.

The failure to ensure people's rights were upheld within the basic principles of the MCA is a continuing breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Initial assessments were not always thorough and this led to care plans not containing sufficient detail to keep people safe. A person with epilepsy and another person who needed frequent observation of their whereabouts did not have adequate care plans for staff to follow.

● Care plans continued to be long and repetitive and did not provide enough individual detail to ensure people received the support to meet their assessed care needs. The registered manager said they were aware the electronic system automatically pulled through automatic text. This could be over ridden by staff but did not always happen. This meant there was a risk crucial information was missed. A person with specific care needs in relation to continence did not have suitable individual information in their care plan to give guidance to staff.

The failure to ensure accurate records are kept is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff had the appropriate support, training, professional development and supervision to enable them to carry out their duties. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Improvements had been made at this inspection and staff now received regular supervision. Training had improved and more staff completed the necessary training. The breach of Regulation 18 was now met. However, further improvement was needed to ensure staff with the right skills were available to meet people's needs.

● The provider had installed new fire evacuation chairs and slings to aid fire evacuation. Staff had not been trained in their use. Instructions for use were posted next to each piece of equipment. There were no records to evidence staff had been shown how to use the equipment safely. A note was made in training audit records that training would be arranged after the COVID-19 pandemic crisis, however, this did not take into account a fire breaking out in the meantime. We spoke to the registered manager who said they would arrange the training as soon as possible.

● Although more staff had completed training courses since the last inspection, there continued to be areas where all staff had not been trained. For example, there were 19 care staff and only six staff had completed catheter care training; people living in the service had a catheter, 12 staff had received epilepsy awareness training; four people living in the service had a diagnosis of epilepsy. This meant staff may not have been equipped with best practice guidance and knowledge on which to base their practice.

● Staff were positive about the training they now had access to. Some staff told us they had not had as many opportunities previously. One staff member said access to training had improved their motivation as their knowledge had increased. Staff practice was observed regularly to check their competency and safety in carrying out specific tasks. Such as administering medicines, moving people and using hoisting equipment.

● Staff received the support they needed to raise concerns and to discuss their personal development

through regular one to one supervision meetings. Staff told us they met regularly with the registered manager and felt well supported. One member of staff told us, "I love it, good working relationship with [registered manager] and everyone. I can talk to [registered manager] about anything."

Supporting people to eat and drink enough to maintain a balanced diet

● People had not always been supported to follow the advice given by healthcare professionals in relation to their food and drink intake. One person had a poor appetite and had steadily lost weight before moving in to the service. A dietician had advised two milky drinks a day as the person was continuing to lose weight on 14 June 2020. There was no evidence the person had consistently received two milky drinks a day as advised. Over a five day period from 22 July 2020, the fluid intake records showed the person had only been given two milky drinks in that time. No other milky drinks had been offered according to records.

● The system in place to check that people had drunk enough to keep themselves healthy and hydrated was poor and inconsistent. There were no formal, recorded checks to show that the daily fluid targets for each person had been reached. The registered manager told us the staff daily allocations sheet should alert staff to people who needed extra support to stay hydrated. However, the records we viewed did not show this. Although monitoring records were poor, we saw people being encouraged to drink fluids during the inspection.

● Meals and drinks were prepared to meet people's preferences and dietary needs. One person told us, "The food is nice." The kitchen staff knew people well. One member of kitchen staff told us how they prepared foods for people with products to replace gluten. They also explained how some desserts were made with sweetener instead of sugar so that people with diabetes could have a healthier dessert.

● People had their meals in the dining room or in their bedrooms. Where people had left food, staff checked that they had finished and asked if they had eaten enough and if they wanted anything else. We saw people being encouraged to drink fluids during the inspection. Snacks were available to people in the lounge area such as fresh fruit, biscuits and crisps.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People had not always received timely access to healthcare services and support. One person needed specialist treatment to their feet and a referral to a health care professional was made by the GP. However, this was over four weeks after they moved in to the service. We spoke with the person, who told us their feet were causing them pain and showed us why. One person reported to staff at around 11am on 29 July 2020 that their catheter was blocked and not working correctly. We spoke with a staff member after lunch to see what action had been taken. Staff called for a district nurse to visit at approximately 2pm. This delay increased the risk of the person suffering increased discomfort and becoming unwell as a result.

● Daily records did not always show action had been taken when people were displaying signs of feeling unwell. One person suffered from regular angina attacks. Their daily records evidenced the person told staff one day they were feeling unwell, they could not breath properly and had chest pain. The records detailed that the staff member passed this on to a senior staff member. There were no further records to evidence what action had been taken, if they had been referred to a healthcare professional, or when they felt better.

● Where people required specialist medical input this was put in place. One person's care records evidenced that they had been seen by a Doctor from the mental health team.

Adapting service, design, decoration to meet people's needs

● The design and layout of the service met people's needs.

● Signposts were in place which helped people living with dementia. People knew where their rooms were and where to find communal areas such as the lounge, dining room, bathrooms and toilets. Most people needed support to move around the service. Toilet seats had been changed to bright colours such as red so

people living with dementia or people with poor vision were able to distinguish them more easily.
● People's rooms had been furnished with items to suit their individual needs, people had pictures, photographs and personal items to ensure their rooms were personalised to their own tastes.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider had failed to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At this inspection, improvements had not been made and the provider was still in breach of Regulation 17.

● Many of the serious concerns we found at this inspection had been raised with the provider at the last inspection. Most of these areas had not been addressed and we found the same issues were ongoing. This meant people's safety had not been consistently assessed, monitored or mitigated.
● Following our last inspection, we imposed conditions on the provider's registration. This included requiring the provider to send a monthly report to update CQC on improvements made. However, the reports we regularly received were not reflective of the areas of concern we found at this inspection.
● The provider had a monitoring system in place to check quality and safety, however, this was still not effective. People's care plans were checked through a manager's audit each month. We looked at audits completed from April – July 2020. Accidents and incidents were included in the audit however, no comment was made about the high numbers of unwitnessed falls. The information recorded did not address the level of risk to people. The registered manager did not record what, if any, action they had taken to improve outcomes for people and to provide a safe service. Lessons had not been learnt from incidents and similar events, increasing the likelihood of them happening again.
● Medicines audits were not robust enough to ensure the safety and quality of medicines management and administration. This had been raised as a concern at the last inspection. Limited audits meant people were at greater risk of running out of their medicines or not receiving them as prescribed. No audits were undertaken of medicines held by people who had been assessed as safe to self-administer and look after their own medicines. This meant the provider and registered manager had limited oversight as to whether people were taking their medicines as prescribed.
● The areas of people's care that required close monitoring, such as food and fluid records and hourly checks were not routinely checked by the provider or registered manager. This meant people were at risk of not receiving the care and support they needed to maintain their health and safety. The registered manager told us they were developing a new audit to include these areas. The audit had not started, despite this being raised as an issue at the last inspection. There was no evidence the provider or registered manager

had identified the concerns we found during this inspection and were in the process of taking action to make improvements.

● The staff training audit was not effective. Action needed to make improvements had not been recorded. For example, the June 2020 audit picked up, as we did during inspection, only 11 out of 30 staff had completed epilepsy training. No action to improve this was recommended or taken. Four people living at the service were diagnosed with epilepsy and all were on prescribed medicine to control seizures.

● Recruitment audits were completed each month. However, they had not picked up any areas of concern, such as the issues we found during the inspection.

● At a staff meeting in February 2020, the registered manager raised their concerns with staff that people appeared to not be offered baths or showers. They highlighted to staff no records had been completed to confirm this since November 2019. Staff were advised they must record if people declined a bath/shower when offered. According to records, people had still not been offered baths and showers regularly. The registered manager had not monitored this closely to check improvements so had not recognised this as an ongoing concern. The registered manager told us the variations in people having baths/showers was down to individual choice. However, bath and shower records for July 2020 showed that two people had not had any baths or showers in the whole month.

The failure to assess, monitor and improve the quality and safety of the service is a continuing breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● At the last inspection a registered manager was not in place. It is a condition of the provider's registration that there is a registered manager at the service. At this inspection, a new manager had been appointed and they had successfully registered with CQC.

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

● At the last inspection, we reported that significant improvements needed to be made to communication, the accuracy of records kept and long and repetitive care planning documents. Staff told us communication had improved, however, we found many improvements were needed to provide a service that focused on improving outcomes for people.

● Staff told us the registered manager and management team supported them well, were approachable and always available to listen to concerns. Staff reported positive changes since the last inspection and the culture and atmosphere in the service had improved One staff member said, "I feel valued, and I did not always feel that before." Another commented, "I am very happy – all the managers are very approachable. There have been many improvements since last inspection."

● Staff said the whole staff worked well together as a team now, for the benefit of people living at the service. One staff member said, "I have noticed the difference in the residents, they are more settled." Another said, "We are more organised, everyone knows what they are doing and there is no confusion."

● The provider had invested in hand-held devices to enable staff to keep more accurate records, which had made some improvement to record keeping. However there continued to be areas of concern.

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 ensure that notifications were submitted to CQC when there was a notifiable event. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At this inspection, improvements had been made and the provider was no longer in breach of Regulation 18.

● The provider and registered manager had made sure notifications were submitted to CQC in a timely manner when notifiable events happened. Registered persons are required to notify CQC without delay of events such as serious injury, deaths, DoLS authorisation and allegations of abuse.
● The registered manager had spoken to people and relatives when incidents occurred and kept them updated.
● The provider had met with people and relatives following the last inspection to speak to them about the findings of the inspection, give reassurance and to share with them how they planned to improve.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were asked their views through meetings and surveys. The provider had held regular meetings with people who lived at Heathfield Residential Home and their relatives, before the COVID-19 pandemic crisis. Information was shared and people were asked for their views. For example, changes to activities or asking for relatives' involvement in care plan reviews.
● A survey in January 2020 showed 25% of people and their relatives did not feel consulted about their care plan. However, only eight relatives responded so 25% was not indicative of many relatives' views. A residents/relatives meeting was held in February 2020 where care plan reviews was discussed, although only three relatives joined the meeting. The next survey was due to be sent out in June 2020, however, this had been delayed. Due to the COVID-19 pandemic, residents' and relatives' meetings and surveys had not yet re-commenced.
● We received positive feedback about the service from a relative following the inspection. They wrote, 'Amazing care given to (my relative) by the management and staff. (Staff member) throughout the lockdown has gone out of (their) way for all the residents and taken time out to (video call) us so we can chat with (my relative) as often as possible. (My relative) is very happy there and it shows when (they) chat to us. We have also been kept updated about the covid (sic) situation and praise them all highly for the care and dedication they have shown, an amazing team of people doing a very hard job especially in these times'.
● The provider had not sent surveys to professionals involved with people's care. We did not receive any negative feedback before or during this inspection.
● The registered manager held staff meetings where staff could raise issues and information could be shared.

Working in partnership with others
● The provider and registered manager liaised with the local authority, CCG and health and social care professionals. The interaction with other agencies had been limited due to COVID-19 restrictions but virtual communication had been made when necessary.

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 11 HSCA RA Regulations 2014 Need for consent The provider and registered manager failed to ensure people's rights were upheld within the basic principles of the MCA. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager failed to take appropriate action to mitigate individual risks. The provider and registered manager failed to take appropriate action to ensure medicines are managed in a safe way. The provider and registered manager failed to monitor incidents to learn lessons and mitigate individual risks. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to assess, monitor and improve the quality and safety of the service. The provider and registered manager failed to

ensure accurate records were kept.

Regulation 17 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider and registered manager failed to ensure staff were recruited safely in to the service by completing the appropriate checks. Regulation 19 (1)