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?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Heathfield Residential Home is a care home providing personal and nursing care to 29 people at the time of the inspection, some of whom lived with dementia. The service can support up to 35 people.

The service was provided across two floors of one adapted building. Most of the people living at the service were permanent residents. However, the service also provided respite care to people who required it for short periods of time. At the time of the inspection no one was staying there for respite.

People's experience of using this service and what we found
Feedback from people and their relatives was mixed. Although most people were happy with their care they did raise some concerns. One relative said, "If I was assessing them I would give them seven out of 10."

Some measures to keep people safe were not always in place. Risk assessments had not been fully completed. This meant there was a lack of information for staff on how to keep people safe. Where there were risks, the actions planned to keep people safe were not always monitored. For example, where people were at risk of dehydration, records on how much the person had drunk were poor.

The service had systems and processes in place to safely administer, record and store medicines. However, these were not followed, and people were not getting their medicines as prescribed. Internal audits by the provider had identified several of the issues the inspection team saw on the day, but had not managed to rectify these and embed good practice around the safe and effective management of medicines.

Safeguarding incidents were not always reported to the local authority to review and investigate. Staff had not always completed safeguarding training to ensure they understood how to keep people safe from abuse. When incidents had occurred, they were not always reported and there was a lack of information about actions that had been taken to keep people safe. This meant opportunities to prevent these concerns from arising again were missed.

Staff had not always been recruited safely. For example, records did not include a full employment history, or a written explanation of any gaps in employment. On the first day of the inspection there was insufficient staff to support people and people had been left waiting for support. However, staffing levels were increased on the second day after we raised concerns.

When people moved to the service their needs were assessed. However, the assessment had not been used to effectively plan people's support and ensure that there were sufficient staff with the skills they needed to support people. People's emotional support needs had not been adequately considered and there had been no recorded efforts made to reduce anxious or emotional based behaviour.

Staff had not completed the training or induction they needed to provide people with effective support.

There were times where staff had not provided good support to people. Staff were not well supported or supervised.

People's capacity had been assessed. However, some people had variable capacity, and this had not been taken in to account. Legal safeguards were not always in place where people were not safe to leave the home unsupported. This meant some people were being deprived of their liberty without an appropriate assessment to determine if this was lawful or appropriate. Some people had been recorded as having capacity to make their own decisions, however decisions had also been recorded as having been taken on their behalf. 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.

Support to maintain nutrition and hydration was not as effective as it could have been. Where people had been unwell and lost a significant amount of weight action had not been taken to support the person with nutrition. People had access to healthcare services. However, some people would have benefited from more support from health and social care professionals such as the occupational therapist to improve their care. There was a lack of support to maintain dental hygiene and people's dental needs had not been fully assessed.

The service was clean, and the decoration well maintained. However, a number of people were living with dementia and there were areas where the decoration could be more dementia friendly.

There were areas where people could be treated with more dignity and respect. For example, some people would benefit from more support when they were eating. People's privacy was not always well maintained as staff accessed people's records on a computer in a public space and the screen was visible to people and their relatives. We made a recommendation about this.

There was a lack of person-centred information about what people could do for themselves. This meant there was a risk that people's independence would not be promoted or maintained. We made a recommendation about this. There was a lack of information about people's preferences and we saw some incidents were their preferences were not met. Care plans including end of life plans lacked detail. Care plans were confusing and difficult for staff to read and staff relied on verbal information. This meant there was a risk that changes to people's care would not be identified by staff.

The service was not well managed. Communication between staff and management needed to be improved and staff were not regularly or effectively supervised. Checks on the quality of the service had not identified concerns and opportunities to improve people's care had been missed.

The provider had not met their legal obligations to report notifiable events to CQC. Prior to the inspection the management team had recently started working with local authority and health professionals to make improvements. However, there had not been sufficient time for this to have impact.

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 Requires Improvement (published on 28 January 2019). At the last inspection there were two breaches of the regulations.

At this inspection the service had deteriorated, and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about a number of areas including staffing levels, medicines management, non-reporting of concern and safeguarding incidents. A decision was made for us to inspect earlier than planned to examine those risks.

We have found evidence that the provider needs to make improvements in all sections of this full report.

Enforcement
We have identified breaches in relation to safe care and medicines, governance, person centred care, safeguarding people, consent, staff training, recruitment and notifying CQC.

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 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 is therefore 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?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive 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
This inspection was carried out by two inspectors, one medicines inspector and one Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Heathfield Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 did not have a manager registered with the Care Quality Commission. This means only the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, Healthwatch and professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and

social care services in England. Health watch had not visited the service and did not provide feedback. However, we received feedback from four health and social care professionals prior to the inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 14 people who used the service and two relatives about their experience of the care provided. We spoke with nine members of staff including the provider, the manager, the area manager, care workers, agency care staff and a temporary chef. We also spoke with the care staff who administered medicines and a pharmacist from the local clinical commissioning group who was supporting the home.

We reviewed a range of records. This included ten people's care records and medication medicines records for 14 people. We looked at five staff files in relation to recruitment and seven staff files in relation to staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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 Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection the provider had failed to ensure that medicines were managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the management of medicines had deteriorated, and the provider was still in breach of regulation 12.

● Records showed that people were not always receiving their medicines as prescribed. There were multiple gaps in medicines administration records which had not been identified or investigated by the provider.
● Medicines which have special administration requirements, such as those needing to be taken with food, were sometimes omitted due to staff not adjusting medicine round routines to meet the requirements of the medicines. No attempt had been made to contact a health care professional for advice where doses had been omitted. This meant there was a risk that people's health could be affected from not having their medicines.
● Medicines were not stored safely and securely in the clinic room. Medicines trolleys were not secured to the wall when not in use. Additional medicines were not stored in lockable cabinets as is recommended in NICE (National Institute for Health and Care Excellence) guidelines or in the provider's own policies.
● We saw multiple examples where antibiotics were given beyond the number of days treatment the prescriber had intended. This was against good practice and antimicrobial stewardship (a national effort to reduce resistance to antibiotics.)
● People taking time critical medicines were frequently not given their medicines at the correct time. There was no additional information to support staff with how to manage these types of medicines or what to do if a dose was missed or delayed. The provider had failed to communicate with peoples' specialists or specialist nurses to seek help on effectively managing the condition.
● Staff did not work in line with legislation and the provider's policies and procedures around the safe and secure handling of medicines. Controlled drugs (medicines which are controlled under the Misuse of Drugs legislation) were not monitored or recorded fully. We saw examples where additional checks and records for administration of these medicines was incomplete.
● Where people were administering their own medicines, appropriate risk assessments were in place. However, the provider was not complying with its own policies and national recommendations around the safe storage and monitoring of these medicines.
● Medicines administration rounds routinely went on for extended periods of time meaning that medicines given later in the day were administered without appropriate space between doses or were given later than

the prescriber intended. On the second day of the inspection there was an extra member of staff administering medicines and the time taken to complete administering medicines was reduced.

The provider had failed to ensure that medicines were managed safely. This was a continued breach of Regulation 12 (2)(g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Systems and processes to safeguard people from the risk of abuse;
● Systems and processes were not operated effectively to prevent the risk of abuse and ensure that concerns were investigated by the appropriate authorities.
● Concerns had not been reported to the safeguarding team at the local authority when they needed to be. For example, where two people had left the service unsupported, when it was not safe for them to do so. One person had left the service previously and action had not been taken to prevent the concern from happening again. There was clear information in the person's care plan that they were restricted from going out. The provider had not put the proper legal authorisations for this. This meant that the person was being deprived of their liberty without lawful authority.
● The actions the service had taken had not proved effective and people had left the service on three separate occasions. Since the inspection keypads had been put in place to reduce this risk of this occurring again.
● Only 23% of staff had completed safeguarding training and some staff did not know how to report concerns outside of the service, if they felt the concern had not been reported or addressed appropriately. However, since the number of staff having undertaken this training has increased to 59%.

Systems and processes were not operated effectively 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to people were not fully assessed. There was a lack of clear and relevant information for staff on how to support people to remain safe.
● Risk assessments were not always in place. For example, there were not always risk assessments for skin integrity were there should have been. One person's behaviour had meant that they had caused damage to their own skin and there was no plan in place to prevent this from re-occurring.
● Adequate monitoring of risks was not in place. For example, one person living with dementia was at risk of urine infections and had recently been treated for an infection. Care plans lacked information about this such as the signs and symptoms of an infection to enable staff to identify that there was a further concern. Staff were not monitoring the person's fluid intake to reduce the risk of an infection occurring. On one day there was only 200ml of fluid intake recorded.
● Risks to the environment were not always mitigated. For example, there were no records of fire drills having been undertaken. People's evacuation plans lacked the level of detail staff would need to assist people in the event of a fire. This put people and staff at risk in the event of a fire. The doors to a cupboard were not always locked when they should have been. Behind the door was a stepped concrete floor and hot water pipes. This meant there was a risk someone could fall down the steps or scald themselves on the pipe. Cleaning products were left unattended where people could access them. This meant there was a risk could ingest liquids that could cause them harm We raised these concerns with the manager at the time of the inspection.
● Some people could display behaviour that could upset themselves or other people and there were no plans in place to reduce this risk and no information for staff about this.

● When things went wrong opportunities to learn lessons and prevent further concerns were missed. Incidents of behaviours were not always appropriately recorded, analysed or acted upon. There were no plans in place to prevent a re-occurrence. Following incidents there had been no debriefing for staff or discussions about how support could be improved, lessons had not been learnt.
● We identified incidents which had not been properly reported and the manager was not aware that some events had taken place. For example, one incident where a person became distressed during support from staff. This meant the manager lacked oversight of events that had occurred and could not take action to prevent them from occurring again.
● The provider kept no records of errors or incidents around medicines management. They were unable to provide any examples of learning from these types of incidents or changes to practice to prevent errors from happening in the future.

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 (2)(a)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Learning lessons when things go wrong
● When things went wrong opportunities to learn lessons and prevent further concerns were missed.
● Incidents of behaviours were not always appropriately recorded, analysed or acted upon. There were no plans in place to prevent a re-occurrence. Following incidents there had been no debriefing for staff or discussions about how support could be improved, lessons had not been learnt.
● We identified incidents which had not been properly reported and the manager was not aware that some events had taken place. For example, one incident where a person became distressed during support from staff. This meant the manager lacked oversight of events that had occurred and could not take action to prevent them from occurring again.
● The provider kept no records of errors or incidents around medicines management. They were unable to provide any examples of learning from these types of incidents or changes to practice to prevent errors from happening in the future.

Staffing and recruitment
● Staff had not always been recruited safely. Records did not include a full employment history, or a written explanation of any gaps in employment. Interview notes were not available for some staff and employment references had not been verified. One reference needed to be followed up for further information and this had not been done.

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.

● 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.

● There was insufficient staff to support people. One the first day of the inspection call bells rang constantly with people seeking assistance from staff. On more than one occasion we saw that call bells had been ringing for more than 10 minutes and not responded too. One staff said, "Sometimes when there is not enough staff you feel more stressed and yes you can get immune to the buzzer."
● We found one person in their room distressed, in an undignified situation and in need of assistance. The

inspector rang the call bell 4 times but got no response. The inspector eventually had to called out to attract staff's attention as staff were busy elsewhere.

● We saw incidents that could have been prevented if there had been more staff to attend people. For example, on 4 November 2019 one person was displaying a known behaviour. Staff had documented that they had seen the behaviour but had to leave the person and go and attend to someone else. Left unattended the persons behaviour had escalated resulting in them entering another person's room and being distressed and angry for over an hour.

● The manager had completed a dependency tool and the rota was covered with the assistance of agency staff. However, the dependency tool had not taken in to account the layout of the building or people's dementia related needs and needed to be reviewed. For example, the manager told us that one person repeatedly requested help from staff and we observed this on the day. However, their emotional support needs had been assessed as low.

● People said, "I think the staff are very busy", "Eventually when they come they say 'I will be with you in 3 minutes' but it never is. I think they have to rush from one person to another."

● One person who was moving in to the service during the inspection was visibly upset. The person's emotional support needs had not been fully considered and there was no staff member assigned to sit with the person and support them to settle in.

● We raised this with the manager and on the second day of the inspection there was an extra member of staff and the situation improved. One staff said, "Today is lovely and you don't feel rushed." However, we could not be entirely confident these increased staffing levels would be sustained or that staffing levels would be adequately adapted to meet needs if new people move in to the service.

The provider had failed to make sure there were sufficient numbers of staff to support people. This was a breach of Regulation 18 (1) (staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Preventing and controlling infection

● Hand hygiene and infection control discussed were discussed at staff meetings. We saw that staff wore personal protective equipment such as gloves and aprons. However, only 12% of staff had completed infection control training. This is an area for improvement.

● Care staff were supported by cleaners and a laundry assistant and the service was clean.

● Staff had access to personal protective equipment and used it appropriately.

Inadequate

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 Good. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
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 found that they were not.
● The management teams understanding of the MCA was poor. For example, one person's capacity assessment stated they had capacity. However, the persons care plan stated they had been unable to make all decisions about their day to day care and that a decision had been made in the person's best interest. Details of what the specific decision was, was not clear in the documentation.
● Care plans relating to consent were confusing and unclear. For example, one person's care plan stated they had capacity to make decisions and give consent. However, it also stated that a relative had been granted authority to make financial decisions for the person. We asked the manager who had made a particular decision relating to care and treatment for this person. They told us the persons relative had done so.
● Some people's care plans stated they had capacity. However, there was sufficient evidence to determine that some people had variable capacity. This had not been taken in to account when planning their care.

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 2008 (Regulated Activities) 2014.

● DoLS were not in place where they should have been. Only two service users had DoLS in place at the time of the inspection and the manager agreed that some people would not be safe to leave the service and should have DoLs in place. The doors to the service were locked and alarmed and people were not free to leave without staff's assistance to do so. At the inspection the manager agreed to review DoLs for people and to put in applications where these were needed.

Staff support: induction, training, skills and experience

● Staff did not have the training they needed to provide people with effective support. There were significant gaps in staff training and not all staff had completed the training they needed including safeguarding, fire safety, consent, challenging behaviour, dementia awareness and equality and diversity. This had an impact on people. For example, behaviour that challenged should have been supported more effectively. Since the inspection some staff had completed more training. For example, the number of staff having completed infection control training had increased from 12% to 19%. However, significant improvement was still needed.

● Staff had not completed catheter care training before one person with a catheter who was staying at the service for respite. When the person left the service, concerns were raised by the persons relative to by the local authority about this person's catheter care.

● Staff did not always complete a proper induction to the service. There was no evidence that some new staff had spent time reading people's care plans or undertaking any training prior to commencing in the role. Permanent staff had completed a period of shadowing of more experienced member of staff before working alone. However, agency staff had not undertaken shadowing or a proper induction and we observed new agency staff supporting people alone. This meant there was a risk they would not know how to support people safely and effectively.

● Competency checks for moving and handling had not been completed for seven staff. Moving and handling training needed to be improved. For example, we observed staff supporting one person with a hoist. Staff failed to check that the person's arms were in a safe position before moving the person. The chair the person was moving from was positioned a long way from the chair they were moving to, meaning that the person was moved a longer distance in the hoist than they needed to be. Although the person did not come to any harm staff practice needed to be improved and monitored to reduce the risk of harm in the future.

● Staff were not well supported. The providers policy was that staff had supervisions once per quarter. However, this had not happened. For example, one member of staff started in June 2019 and there was no record they had undertaken any supervisions.

Persons employed by the provider must receive appropriate support, training, professional development and supervision to enable them to carry out their duties. This was a breach of Regulation 18 (2)(a) (Staffing) 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

● People's needs had been assessed. However, assessments had not been used to plan effective care and support. For example, staff skills and training had not been considered when accepting new people in to the service.

● Since July 2019 the manager told us that eight new people had moved in to the service including two people on the first day of the inspection. Six people had also come to the service for respite. The manager told us they were aware there were issues relating to staff recruitment and care planning. The audit completed by staff at the service in November 2019 identified that there were issues with staff training. None of these concerns had been taken in to consideration when making the decision to accept new admissions for respite or permanent care.

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

● Effective support to promote eating was not always in place. For example, one person was at risk from malnutrition. They had recently lost a significant amount weight due to being unwell, although they were not underweight. The person had a digestive condition which meant there were times they did not eat well and there was a possible risk that some foods could cause upset. However, the staff had not sought the

support of a dietician and there was no plan in place to promote nutrition or reduce the risk of digestive pain. We raised this with the manager at the time of the inspection.

● Where people were at risk of dehydration fluid intake was not well recorded. For example, on 16 November 2019 there was no record of one person being offered a drink between 10am and 6.39pm. This meant there was a lack of oversight on what people had drunk so staff could monitor people's hydration.

● We observed people being offered a choice of drinks throughout the day. The majority of people told us they thought the food was very good and they were offered a choice. One person said, "I enjoy my food and you can always have something different". However, another person told us "I think [the food] is too dry."

● People had a choice of meals. For example, one person was upset and unhappy with their meal. Staff offered the person an alternative which they ate and enjoyed. There were bowls on snacks available for people in the lounge. However, we did not see staff offer these to people.

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

● Where people were unwell the GP had been called. One person said, "They will send for a GP if you are unwell, they are always very kind to me, I cannot fault them."

● People had been referred to services such as physiotherapists, the nurse and occupational therapists. However, some people would have benefited from more support. For example, we observed staff were unable to persuade one person to put their feet on their wheel chair foot plates. After a persisting for a while staff gave up and wheeled the person to their room with their feet in an unsafe position. Staff had not referred the person to an occupational therapist to review how the person could be better supported. We raised this concern with the manager at the time of the inspection as this is an area for improvement.

● There was information in people's care plans to support oral hygiene. However, staff had not yet completed oral hygiene training although the manager told us that training was booked. Oral hygiene assessments for people had not yet been completed. There was no dentist visiting the service and we were not able to evidence that people had seen a dentist for regular check-ups. This was an area for improvement.

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

● The environment was not as dementia friendly as it could have been and did not meet best practice guidelines. For example, toilets were white with white seats; best practice guidelines recommend that these are of contrasting colours. People's doors were all the same colour, and most were not personalised. The use of signage and reference points was limited, this could be improved to assist people to find the toilet or their own room independently. There was no quiet space for people to sit except if they went to their own room. This was exacerbated by the constant ringing of call bells. One person said, "They get on my nerves". This is an area for improvement.

● There was an accessible outside space at the service which included seating and grass areas. Staff told us that one person smoked. However, there was no shelter where they could go and sit if it was raining. This is an area for improvement.

● The decoration at the service had been maintained and people had personalised their rooms. There was a lift to support people to access the second floor.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- The provider had not ensured that people were being treated with dignity and respect in that systems to keep people safe from harm and protect them from risk were not robust, there had not always been sufficient staff to support people.
- Assessments of people's needs had not always taken in to account the support people needed to maintain their dignity. For example, during the inspection we saw people eating alone in the dining room who would have benefited from more staff support to complete their meal in a dignified manner.
- Staff knocked on people's doors before they entered to help maintain their privacy. However, care plans and daily notes were stored on computers which were accessed in the main lounge by staff frequently thought the day. This meant when staff were updating people's records information about people was in full view of people and their visitors. When the computers were not being used people's pictures and names remained on view. This demonstrated that people's privacy was not respected. Since the inspection to provider has written to us to tell us that staff will be issued with hand held devices to reduce the risk of people's privacy being violated.
- Care plans lacked details about what people could do for themselves which meant there was a risk that staff would not know how to promote people's independence. For example, one person's care plan stated that the person wished to maintain their current level of independence, ability and confidence. However, there was no information to support this such as what personal care they could do unsupported.

We recommend that the provider reviews systems, documentation and people's support to ensure that independence, dignity and respect are promoted.

Ensuring people are well treated and supported; respecting equality and diversity
- People told us that staff were kind to them. Comments included, "They are very caring. They say to me if you ever want anything I can try to get I for you. I look upon them as friends", "I am happy and think the carers work hard and are committed to completing their tasks. I am content, I can have a shower when I want one, but I am supervised is conducted in a dignified and respectful manner" and "Staff are kind and considerate, they really show they care",
- We observed staff spoke with people in a kind way and bent down to their level to talk with them when they were seated. However, there were occasions where staff practice could be improved. For example, we observed one person waiting to be hoisted. Three staff stood over the person discussing their break times while they waited for support. This is an area for improvement.

Supporting people to express their views and be involved in making decisions about their care

● People had been involved in planning their care. Where people had difficulty expressing their views relatives and people who were important to them had been involved in care planning.
● One person said, "I have two care plans. One is for the management of [a health condition] and I discuss that one with the community nurse and the wider one for the care home."
● Where people needed support to communicate this was in place. For example, one person had picture cards to let staff know when they wanted a drink or support.

Requires Improvement

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 Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- There was limited information on people's preferences. For example, one person had moved in to the service temporarily and had declined to get out of bed early six days running. One morning it was recorded that the person became agitated when asked if they wanted to get up at 7:04am. They were asked again at 7:50am and staff recorded that the person was cross with them. The next morning, they were asked if they wanted to get up at 6:50am and again they declined. There were no records to show that the person had been asked what time they preferred to get up in the mornings.
- Where preferences had been expressed they were not always met. For example, one person's care plan stated they wanted personal care to be delivered by female care workers only. During the inspection we saw a male care worker provided this person with personal care.
- Care plans had been updated regularly. However, they lacked detail and were not always personalised. For example, more than one person's care plan made reference to memory aids and said that it was important to the person. We asked staff and the manager about these and found these were not in place and the information was not relevant to those people.
- No one at the service was being supported with end of life care. However, they had been in the past.
- End of life care plans lacked detail. For example, there was no information on what people wanted to happen to their possessions. There was a lack of personalised information such as whether they wanted music in their room or flowers at their funeral. One person had recently passed away. Care had been taken to ensure that their funeral could take place in a way which respected their religion. However, this was not documented in the care plan and there was no information to clarify if the person wanted any other religious support prior to their death.

The provider had not ensured that care provided to people was person centred. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The manager was not aware of the AIS at the time of the inspection. Information was not always provided in an easy read format such as pictorially or in large print. For example, the menu was not in picture format and the complaints policy was not available in large print.

The provider had not ensured that people were provided with accessible to enable them to be involved in

decisions about their care. This was a breach of Regulation 9 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 the last inspection this was an area for improvement as there was no activities coordinator and feedback from people and their relatives was that there could be more activities to interest people. At this inspection this remained an area for improvement.

● After the last inspection the service had employed an activity co-ordinator. However, they had recently left the service and had not yet been replaced although the provider told us they were in the process of recruiting a replacement. One person said, "Everyone thought they were very good, and they are missed."
● In the afternoon of the first day of the inspection there was an outside entertainer which people enjoyed. However, there were no activities on the second day and there were long periods of time where people were not engaged in an activity. One person told us, they were lonely and there was there was nothing much to do. This is an area for improvement.
● People's relatives told us that they were free to visit people when they wanted to do so.

Improving care quality in response to complaints or concerns
● There were no recorded complaints at the service since the last inspection. One person said, "I have never made a complaint, but I would go and talk to the manager if any problems arose." However, the manager was aware that one relative was unhappy with the service and not made a record of this. There was no information on what concerns the relative had raised or what action had been taken to address it. This was an area for improvement.
● There continues to be a complaints policy in place and people had been provided with a copy of this.

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 Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service. 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 the governance of the service had not improved, and the provider was still in breach of regulation 17 for the third consecutive time.

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

- The culture at the service needed to be improved. Staff had not raised concerns with the manager when they occurred, and communication needed to be significantly improved. Staff meetings were not frequent, and the last recorded meeting was on 30 August 2019 and records showed that there were a significant number of staff who did not attend. Prior to that the previous meeting was on 24 April 2019. There were no records made of staff having the opportunity to raise areas they wished to discuss at staff meetings.
- Record keeping at the service was very poor. Staff had to access one of two computers in the lounge area to update people's records. This had a significant impact on staff recording as staff had to wait to update people's records. We received feedback from a number of health and social care professionals who raised concerns about the lack of accurate records. For example, records for one person with a catheter did not show the being bag checked or being emptied on 08 October 2019 between 8.38am and 9pm. At 9pm the fluid output was recorded as nil. This mean there were no records of how much fluid the person had passed, and staff could not identify concerns if the person had been retaining fluid.
- Care plans were long and repetitive and at times incorrect. For example, information on mental capacity was repeated over and over in different sections of the care plan but was not always accurate. This made them very difficult to follow. Staff told us they relied on verbal information to know how to support people.

Continuous learning and improving care

- Checks on the quality and safety of the service were not effective. The provider lacked oversight of the service and was not aware of some of the concerns we found at the inspection.
- Medicines audits completed by the provider covered a wide range of areas and had identified some issues where improvement was needed. However, the provider had not acted on the results of their audit work and made changes to practice improving the safe and effective handling of medicines. A number of the issues identified in these audits were still ongoing at the time of the inspection.
- Audits had not identified the significant shortfalls we found at inspection. For example, the audit of daily

records completed in November found that daily records were detailed. However, we found there was a significant lack of detail in these records. The audit completed in October 2019 stated that care plans contained personalised information. However, we found that care plans were often repetitive and not person centred.

● The manager had experience in domiciliary care but had not worked in a management position in residential care. The provider had not arranged for the manager to attend any further training courses and the manager had not attended any learning events and they would have benefited from doing so. However, since the inspection the manager has left and there is an acting manager in place who has experience of managing residential care. A deputy manager is also in the process of being recruited.

● The service has been rated Requires Improvement at the previous two inspections. However, the provider had failed to make improvements and learn lessons. The standards of care had deteriorated to Inadequate at this inspection.

The provider had failed to assess, monitor and improve the quality and safety of the services. The provider had failed to maintain complete, accurate and counteroperations records. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had failed to ensure that significant events were reported to CQC. CQC had not been informed in a timely manner about incidents and safe guarding's that had occurred at the service. For example, CQC had not been notified when the police had been called after a person had left the service unsupported.

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.

● Incident reporting and recording were poor. Therefore, we were not able to be certain that there had been no incidents which qualified as duty of candour incidents. A duty of candour incident is where an unintended or unexpected incident occurs which result in the death of a service user, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.

● Where incidents had occurred, they had had not always been responded to appropriately and feedback was that the service had not always informed relatives in a timely way. This is an area for improvement.

● There was no registered manager at the service. The previous manager had de-registered with CQC on 23 May 2019 and a new manager had started at the service on 07 July 2019. The new manager had submitted an application to register dated 28 August 2019. This had been rejected as the manager had not completed a countersigned DBS check which is a pre-requirement for registering. The manager told us that they were submitting their DBS check. However, at the time of report writing there were no records of this having been received. It is a condition of the providers registration that there is a registered manager at the service.

● The rating was on display at the service and on the providers website and was accessible for people and their visitors to view. This is a legal requirement.

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

● Surveys for people had not been completed since the last inspection. However, these were being prepared at the time of the inspection and were only just due.

● The provider had not sent surveys to professionals involved with people's care. The feedback we had from professionals about the service was in the majority not positive.

Working in partnership with others

● Prior to the inspection the service had recently started working with local health and social care professionals such as the local authority and the local clinical commissioning group (CCG) to address concerns. This engagement was too recent to have had a significant impact on the quality of the service and was instigated by external organisations after concerns about the service had arisen. However, the feedback we received was that management team were engaging with this support and were keen to improve.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure that notifications were submitted to CQC when there was a notifiable event.

The enforcement action we took:

We imposed conditions of registration against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that care provided to people was person centred.

The enforcement action we took:

We imposed conditions of registration against 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 had failed to ensure that care and treatment of people was only provided with the consent of the relevant person.

The enforcement action we took:

We imposed conditions of registration against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that medicines were managed safely. 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.

The enforcement action we took:

We imposed conditions of registration against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not operated effectively to investigate and immediately act upon any allegations of abuse.

The enforcement action we took:

We imposed conditions of registration against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the services. The provider failed to maintain and accurate, complete and contemporaneous record in respect of each service user.

The enforcement action we took:

We imposed conditions of registration against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered manager had not completed the appropriate checks to ensure that staff were recruited safely in to the service.

The enforcement action we took:

We imposed conditions of registration against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to make sure there were sufficient numbers of suitably qualified and competent staff.

The enforcement action we took:

We imposed conditions of registration against the provider.