Malhotra Care Homes Limited

Heatherfield Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Heatherfield Care Home provides accommodation, nursing and personal care to a maximum of 74 people. At the time of the inspection 69 people were receiving support across three separate units, specialising in nursing care, younger people and dementia care.

People's experience of using this service and what we found
A safeguarding system was in place; however, this was not always operated effectively. Records did not always evidence what actions had been taken to ensure people were safe.

Risk was not always safely monitored and managed. The provider had systems in place to analyse and monitor accidents and incidents, complaints and safeguarding. However, these were not always followed or operated effectively to ensure risks, trends and themes were identified, recorded, reported and monitored.

There was an infection control system in place. However, records did not always evidence that staff followed government guidance in relation to COVID-19 testing. In addition, an effective system to reduce the risk of visitors spreading infection was not fully in place. We observed that staff used PPE effectively and safely.

Medicines were managed safely, however, records were not in line with the provider's policy.

Whilst there were sufficient numbers of staff on duty; due to the impact of Brexit, COVID-19, vaccination as a condition of employment and staff leaving the sector, the use of agency staff had increased. This had affected the skill mix of staff on duty. People and relatives told us the permanent staff were skilled and knowledgeable about people's needs. However, they were not as positive about the skills of the agency staff. The provider had recruited new staff which would reduce the use of agency staff and provided additional training for agency staff.

Whilst the provider had quality monitoring and communication systems in place; these were not always operated effectively. In addition, an effective system to ensure notifiable events at the home were reported to CQC was not fully in place. This is being dealt with outside of the inspection process.

The provider sent us several case studies to show how being at the home, with the support of staff, had led to an improvement in people's health, independence and wellbeing. They also sent us compliments which had been received from relatives. Positive feedback was received from health and social care professionals about the staff and people's care and support.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 17 February 2021).

Why we inspected
The inspection was prompted due to concerns received about people's care and treatment. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last comprehensive inspection to calculate the overall rating.

The local authority had placed the home into 'organisational safeguarding.' This meant the local authority was monitoring the home and supporting them to ensure the correct procedures were in place to keep people safe. The provider was cooperating with this.

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

We have found evidence that the provider needs to make improvements. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance. We also identified a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (notification of other incidents).

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response in relation to Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (notification of other incidents) is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Heatherfield Care 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 two inspectors, a pharmacy inspector and an 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
Heatherfield Care 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 home 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. The registered manager left at the end of the inspection and was working elsewhere within the provider's organisation. A new manager had been appointed.

Notice of inspection
The 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. A provider information return was completed. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people, 14 relatives and 19 staff including the nominated individual, director of care. head of compliance, registered manager, nursing staff, senior care workers, care workers, (including agency care workers) the administrator, housekeeping staff and activities coordinators. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included people's care records, medicines records and information relating to staff recruitment. A variety of records relating to the management of the service, including policies and procedures were also examined.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also reviewed evidence and information which the provider sent us electronically following our feedback.

Requires Improvement

Is the service safe?

Our findings

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

At the previous inspection, this key question was rated good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- A safeguarding system was in place; however, this was not always operated effectively. Records did not always evidence what actions had been taken to ensure people were safe.

The failure to ensure the safeguarding system was operated effectively was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management; learning lessons when things go wrong; preventing and controlling infection

- Risk was not always safely monitored and managed. The provider had systems in place to analyse and monitor accidents and incidents, complaints and safeguarding. However, these were not always followed or operated effectively to ensure risks, trends and themes were identified, recorded, reported and monitored. Therefore, the provider could not always ensure that appropriate action could be taken to help prevent any reoccurrence.
- There was an infection control system in place. However, records did not always evidence that staff followed government guidance in relation to COVID-19 testing. In addition, an effective system to reduce the risk of visitors spreading infection was not fully in place.

The failure to ensure the systems to assess, monitor and manage risk were operated effectively and make sure accurate records were maintained was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the inspection we observed that staff used PPE effectively and safely.
- Several relatives told us they were unable to visit in the home because of a COVID-19 outbreak. No essential care givers had been appointed at the time of our visits to the home. The essential care giver role was introduced by the government in March 2021. Essential care givers should be able to visit inside the care home even during periods of isolation and outbreak to provide companionship, emotional support or carry out personal care. After our visits, the provider told us that essential care givers were being appointed.
- From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We found the service had effective measures in place to make sure this requirement was being met.

Using medicines safely

● Medicines were managed safely, however, records were not in line with the provider's policy.
● Records showed fridge temperatures were above and below the recommended ranges to safely store medicines requiring cold storage. These were not escalated for investigation in line with the provider's policy so the registered manager had the assurance that medicines were stored correctly.
● The provider's medicine policy was not followed in relation to record keeping in several areas. Allergies were not always recorded on the medicine administration records. There were incomplete records for the disposal of medicines including those susceptible to misuse. Where people refused medicines, records were not in line with the medicine policy and medicines which were prescribed with a variable dose, the dose administered was not always recorded.
● Records were not always available to support the safe administration of creams and lotions in line with the provider's medicine policy. One member of staff told us they never completed any paperwork after topical medicines were administered as part of personal care.
● Processes in place to record the use of thickening agents (medicines used to thicken food or fluids for people with swallowing difficulties) did not assure us they were being given as prescribed.
● Competency assessments for staff administering medicines were in place, however, care staff had received no training in the application of topical medicines which was an integral part of their role.
● Audits were taking place within the service on the nursing unit however, they did always identify the issues we found on inspection.

The failure to ensure accurate records relating to medicines were maintained was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the first day of inspection, we were shown the improvements the provider had made in relation to the issues we highlighted at feedback. However, we were unable to measure whether these improvements had been fully implemented.

Staffing and recruitment
● Whilst there were sufficient numbers of staff on duty; due to the impact of Brexit, COVID-19, vaccination as a condition of employment and staff leaving the sector, the use of agency staff had increased. This had affected the skill mix of staff on duty. People and relatives told us the permanent staff were skilled and knowledgeable about people's needs. However, they were not as positive about the skills of the agency staff.
● The provider had recruited new staff with a view to reducing the use of agency staff. They also told us they had provided further training for agency staff, "to ensure they meet our high standards."
● Safe recruitment procedures were followed.

Requires Improvement

Is the service well-led?

Our findings

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

At our previous inspections this key question was rated good. At this inspection, this key question has deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

● The provider had a quality monitoring system in place; however, this was not always operated effectively. We identified shortfalls relating to complaints and safeguarding records, the management of risk, infection control and medicines management. These had not been identified by the provider's monitoring system.

The failure to ensure the quality monitoring system was operated effectively to ensure the health and safety of people was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● An effective system to ensure notifiable events and incidents at the home were reported to CQC was not fully in place. This meant there had sometimes been no overview by CQC to check whether suitable action had been taken and people were safe.

This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009. We are dealing with this matter outside of the inspection process.

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

● Records were not fully available to demonstrate how the provider had followed the duty of candour. The provider had devised a checklist and forms to support staff to identify and respond to incidents appropriately, including notifying all relevant persons.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; working in partnership with others

● Whilst the provider had a communication system in place; this was not always operated effectively. Several relatives explained that more communication was required.

● Some staff explained they did not always receive a handover prior to starting their shift. In addition, an effective system to ensure all accidents and safeguarding incidents were identified, recorded and reported appropriately was not fully in place.

The failure to operate an effective communication system within the home to ensure the health and safety of people was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our feedback, the registered manager attended handover meetings to make sure they were effective. Additional staff training regarding the recognition, reporting and recording of incidents was being organised.

● Staff explained that morale had been affected by the pandemic and the impact which this had had upon staffing.
● The provider was working with the local authority and health and social care professionals as part of the organisational safeguarding process.
● The provider sent us several case studies to show how being at the home, with the support of staff, had led to an improvement in people's health, independence and wellbeing. They also sent us compliments which had been received from relatives. Positive feedback was received from health and social care professionals about the staff and people's care and support.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The quality monitoring system was not being operated effectively to ensure people's health and safety. Accurate records were not always maintained. In addition, an effective communication system was not fully in place. Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(e)(f).

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
Treatment of disease, disorder or injury	An effective system to ensure notifiable events and incidents at the home were reported to CQC was not fully in place. Regulation 18 (1)(2)(a)(ii)(b)(ii)(e)(f)(5)(b)(i)(ii)(iv)(g)(i)(ii).

The enforcement action we took:

We did not proceed with enforcement action in respect of this breach