Review of compliance

Heathfield (Horsham) Limited Heathfield (Horsham) Limited	
Region:	South East
Location address:	88 Hurst Road Horsham West Sussex RH12 2DX
Type of service:	Care home service without nursing
Date of Publication:	November 2011
Overview of the service:	Heathfield is a care home without nursing registered to provide personal care and accommodation for up to 36 older people. The home is located on the outskirts of Horsham close to local amenities. It consists of a two-storey building with well-maintained gardens. Both floors are served by a passenger lift. There are 36 single bedrooms 18 of which offer en-

	suite facilities. The communal areas consist of a large sunroom, comfortable lounge and dining areas.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Heathfield (Horsham) Limited was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 2 November 2011, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

People living at the home told us they felt safe living there and that staff were always available when they needed them. They felt the staff knew what they needed and knew how they liked things done.

People we spoke with told us they were involved in making decisions about the way they lived their lives and the care they received. They felt the staff always respected their privacy and dignity and that the staff helped them to remain as independent as possible. Staff knew the people living at the home well and had a good understanding of their care needs.

Feedback on surveys given out by the home and completed by the people who live there were positive.

What we found about the standards we reviewed and how well Heathfield (Horsham) Limited was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

We found that the people who used the service were treated with respect. There were systems in place to ensure that effective interaction took place with the people who lived at the home to establish their views.

Overall, we found that Heathfield was meeting this essential standard.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

We found that people mostly have their care and welfare needs met and that the staff have the knowledge to meet each person's identified needs. However, we found that risk assessments to encourage the early detection of potential falls and patterns of falls are limited resulting in preventative action not being taken for some people.

Overall we found that Heathfield was meeting this essential standard but to maintain this, we suggested that some improvements were made specifically relating to Outcome 21.

Outcome 07: People should be protected from abuse and staff should respect their human rights

We found people are protected from the risks of harm because the staff know how to recognise abuse and how to act if they have any concerns.

Overall, we found that Heathfield was meeting this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

We found that people's health and safety is safeguarded because the home ensures there is enough staff to meet people's needs.

Overall, we found that Heathfield was meeting this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The views of people living, working and visiting the home had been sought and suggestions made have been acted upon.

Overall, we found that Heathfield was meeting this essential standard.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

We found that there were gaps in the home's record keeping. Care notes were not regularly completed and some care plans did not accurately reflect the care being given. There was inconsistency in the recording of falls.

Overall we found that Heathfield was not meeting this essential standard

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We were told that independence and individuality were promoted within the home. People living there told us they were supported and enabled to do things for themselves. They felt the staff always respected their privacy and dignity and that the staff helped them when needed. They said they felt able to express their views and felt involved in their care.

Other evidence
During our visit all interactions we saw between the staff and the people living at the home were respectful and, where required, help was offered and provided in a way that ensured that people's rights to privacy and dignity were respected. People were being spoken with in a sensitive, respectful and professional manner.

We saw staff taking their lead from the people who live at Heathfield and making it possible for them to maintain their independence.

Care plans had been developed for each individual. The care plans we sampled provided some information to staff on how people preferred things to be done. Some of the care plans contained information regarding peoples likes and dislikes in relation to food and daily activities. It was clear that the staff we spoke with knew the people who

live at Heathfield well.

Individuals had their privacy and dignity upheld.

Our judgement
We found that the people who used the service were treated with respect. There were systems in place to ensure that effective interaction took place with the people who lived at the home to establish their views.

Overall, we found that Heathfield was meeting this essential standard.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People we spoke with told us that the staff knew what they needed and how they liked things done.

Other evidence
We were told that there was a robust admission policy and procedure in place. Each person's individual care and support needs were assessed prior to their admission to the home. People were initially admitted for two weeks trial. Following this a satisfaction survey was completed. We saw some completed surveys which included actions taken and changes that had been made at the person's request.

We were told that staff had the relevant knowledge and skills and were competent to meet people's identified needs. We spoke with one member of staff, who confirmed that they feel confident in their role and receive all necessary training and support.

Records confirmed that each person living in the home was registered with a local GP and dentist and have access to other healthcare professionals as necessary. Visits by and appointments with health professionals were recorded in the care notes. We were told that input from the specialist professionals is sought when needed.

During our visit we sampled the care plans and the care notes for the people living at the home. The care plans provided some information to staff on how people preferred things to be done. Some of the care plans contained information regarding peoples likes and dislikes in relation to food and daily activities.

Some of the care plans did not reflect the care being given. For example, one residents care plan stated that they required assistance with bathing, but the care notes did not provide any evidence that the resident had had a bath. Discussion with staff evidenced that the resident preferred not to have a bath and did not usually require assistance with personal hygiene. The people we spoke with told us that the staff knew the care they needed and how they liked things done.

The care notes were not regularly completed; this prevented the home from providing a clear picture of how the people who live at Heathfield had spent their day and the care they had received.

Staff were able to tell us what care and support people living at the home needed and staff had a good knowledge and understanding of the way people liked things done. We were told that the home did not use agency staff and that only staff that knew the people living at the home worked there. It was clear that the staff we spoke with knew the people who live at Heathfield well.

Each care plan we sampled included risk assessments that related to specific and identified risks to people's safety, together with actions staff should take to reduce those risks.

Incidents of falls had been recorded in the care notes but were not routinely recorded in the accident or incident records. There was no guidance for staff regarding which falls needed to be recorded. Staff were using their own judgement depending on the seriousness of the fall. Falls risk assessments had not been reviewed following falls and there was no follow up comments made in the care notes. This method of recording made it difficult for the home to provide accurate data regarding the incidents of falls at the home.

Our judgement
We found that people mostly have their care and welfare needs met and that the staff have the knowledge to meet each person's identified needs. However, we found that risk assessments to encourage the early detection of potential falls and patterns of falls are limited resulting in preventative action not being taken for some people.

Overall we found that Heathfield was meeting this essential standard but to maintain this, we suggested that some improvements were made specifically relating to Outcome 21.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People we spoke with told us they felt safe living at the home and that they would tell the manager or another staff member if they had any concerns.

Other evidence
Staff at the home confirmed that Heathfield operates in accordance with the Sussex Multi Agency Policy & Procedures for Safeguarding Vulnerable Adults. We were told that the home ensures, as far as is practicable, that people living there are safeguarded from all forms of abuse and relevant policies and procedures relating to Safeguarding Vulnerable Adults, including a policy on alerting, 'Whistle Blowing', are in place. In accordance with current legislation, all safeguarding alerts are reported to the local authority, although staff confirmed that to their knowledge there have not been any recent safeguarding alerts or investigations.

Staff confirmed that Safeguarding Vulnerable Adults training is mandatory and recorded for individual staff. This involves ensuring all staff are aware of the various types of abuse and how it may present itself. As part of their induction process, staff are expected to read the whistle blowing policy, and have knowledge of how to report suspected abuse. This was supported by training records viewed and confirmed through discussions with a member of staff during our visit.

Our judgement
We found people are protected from the risks of harm because the staff know how to recognise abuse and how to act if they have any concerns.

Overall, we found that Heathfield was meeting this essential standard.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People we spoke with told us that staff were available when they needed them and that the staff knew what to do when providing their care and helping them to do things.

Other evidence
During our visit, we saw that people living at the home received care in a calm and relaxed manner. We observed that call bells were being answered efficiently and that staff were able to spend time with and interact with people in a positive manner.

Staff spoken with stated that there were sufficient staff in place to be able to give the care that people needed, to a good standard.

We looked at staffing rotas which evidenced that there was an appropriate level of core staffing in place. This was sufficient to meet the needs of the people living at the home. The morning shift was covered by five members of care staff, with four in the evening, two at night with an additional member of staff 'sleeping-in' overnight. A senior member of staff was on call at all times and available if needed. We were told that the home did not use agency staff and that only staff that knew the people living at the home worked there. It was clear that the staff we spoke with knew the people who live at Heathfield well.

Our judgement
We found that people's health and safety is safeguarded because the home ensures there is enough staff to meet people's needs.

Overall, we found that Heathfield was meeting this essential standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People we spoke with told us that they were asked their views about the home and whether they were happy there.

Other evidence
Records showed that surveys are given to the people who live in the home monthly. An analysis of the results then takes place and if any shortfalls are identified an action plan is implemented to rectify them. Information about people's experiences had been gathered in such a way to allow for improvement in the quality of service.

Complaints were logged and reviewed to identify trends. Lessons arising from these had been used to make changes to the service. Staff were confident and aware of how to raise concerns.

Incidents of falls had been recorded in the care notes but were not routinely recorded in the accident or incident records. Risk assessments to encourage the early detection of potential falls and patterns of falls are limited. This method of recording made it difficult for the home to provide accurate data regarding the incidents of falls at the home.

During our visit, we observed people being spoken with and supported in a sensitive, respectful and professional manner. This included assessment of their satisfation and having their needs met. The people living at the home were able to express their views and make suggestions by talking directly to the staff.

Our judgement
The views of people living, working and visiting the home had been sought and suggestions made have been acted upon.

Overall, we found that Heathfield was meeting this essential standard.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are minor concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not receive any comments from the people who live at Heathfield that relate to this outcome area.

Other evidence
During our visit we examined some of the homes records. The records that we saw were not all fully completed.

Some of the care plans did not reflect the care being given. For example, one residents care plan stated that they required assistance with bathing, but the care notes did not provide any evidence that the resident had had a bath.

The care notes were not regularly completed; this prevented the home from providing a clear picture of how the people who live at Heathfield had spent their day and the care they had received.

There was inconsistency regarding the recording of falls. Incidents of falls had been recorded in the care notes but were not always recorded in the accident or incident records. Staff were using their own judgement. There were no follow up comments made in the care notes.

Our judgement

We found that there were gaps in the home's record keeping. Care notes were not regularly completed and some care plans did not accurately reflect the care being given. There was inconsistency in the recording of falls.

Overall we found that Heathfield was not meeting this essential standard

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: We found that people mostly have their care and welfare needs met and that the staff have the knowledge to meet each person's identified needs. However, we found that risk assessments to encourage the early detection of potential falls and patterns of falls are limited resulting in preventative action not being taken for some people.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: We found that there were gaps in the home's record keeping. Care notes were not regularly completed and some care plans did not accurately reflect the care being given. There was inconsistency in the recording of falls.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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