RYSA Highfield Manor Limited

Highfield Manor Care Home

Inspection report

44 Branksome Wood Road
Bournemouth
Dorset
BH4 9LA
Tel:
Website:

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 1, 2 and 15 October 2014. Breaches of legal requirements were found and we issued a warning notice for breaches in medicines management. The provider was required to meet the regulation by 14 November 2014.

As a result we undertook an unannounced focused inspection on 22 December 2014 to follow up on whether action had been taken to deal with the breach.

You can read a summary of our findings from both inspections below.

Comprehensive Inspection of 1, 2 and 15 October 2014

This was an unannounced inspection on 1, 2 and 15 October 2014.

Highfield Manor is registered to provide personal care for up to 46 people living with dementia. Nursing care is not provided. There were 45 people living at the home when inspected. The registered manager is also one of the directors of the provider RYSA Highfield Manor Limited. A

Summary of findings

registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

There were unsafe arrangements for the management and administration of medicines that put people at risk of harm. People were given sedative medicines routinely rather than when needed them and as prescribed by their GP. These people were subject to sedation at times when they did not need it and this placed them at risk of harm.

Policies about keeping people safe and reporting allegations of abuse were out of date and one member of staff was not sure how they should respond to abuse.

Any risks to people's safety were not consistently assessed and managed to minimise risks. For example, behaviours that may challenge others and emergencies had not been risk assessed and planned for so staff knew what action to take. People's needs were not reassessed when their circumstances changed and care plans were not updated or did not include all the information staff needed to be able to care for people. This meant that for some people prompt action or referrals were not made to the right healthcare professionals and they did not receive the care they needed. People's need for social stimulation, occupation and activities were not consistently met.

People's care and monitoring records were not consistently maintained and we could not be sure they accurately reflected the care and support provided to people.

Staff did not have the right skills and knowledge to provide personalised care for people living with dementia. This was because they did not have a full induction into care, the right training or regular support and developments sessions with their managers.

Staff did not fully understand about the Mental Capacity Act 2005, and how to assess people's capacity to make specific decisions or about those people who were being restricted under Deprivation of Liberties Safeguards. This meant that some people may have been unlawfully deprived of their liberty or had restrictions place on them.

Some people had lost weight and prompt action had not been taken to ensure they had high calorie and high fat foods such as cream to increase their weight. Food and fluid plans were not in place for people who were at risk of losing weight so that staff knew what action to take to support them.

Information about making complaints was not displayed and contact information was incorrect. There were mixed views from relatives about whether they felt able to complain about the home.

The systems in place and the culture at the home did not ensure the service was well-led. This was because people were not encouraged to be involved in the home. People were not consulted, staff were not consulted and the quality assurance systems in place did not identify shortfalls in the service. The service did not have effective systems in place to ensure it was well led and people received a good service.

There were enough staff on duty during the inspection to meet people's needs and staff were recruited safely to make sure they were suitable to work with people. There were staff meetings and handovers to share information between staff.

Staff were caring and treated people with dignity and respect. Staff knew people's basic care needs and some personal information about them. We saw good relationships and interactions between some staff and people.

At our last inspection in November 2013 we did not identify any concerns.

Focused inspection of 22 December 2014

After our inspections of 1, 2 and 15 October 2014 the provider was served a warning notice in relation to medicines management. This required the service to be compliant by 14 November 2014. We undertook this unannounced focused inspection to check that the breach of the regulations had been addressed.

The provider had developed a plan to address the shortfalls with an independent pharmacist appointed by

Summary of findings

the local authority. The independent pharmacist was appointed because of the concerns relating to medicines management. We found that the provider had followed their plan in relation to meeting this regulation. However, medicines were not stored at their recommended temperatures and appropriate actions had not been taken when this was identified by staff. This was an area for improvement because the incorrect fridge temperatures could affect the effectiveness of people's medicines.

People's medicines had been reviewed by their GPs. Following these reviews the prescribing, dispensing and Medication Administration Records (MAR) were being updated to reflect these changes. Care plans were in place for people who were prescribed 'as needed' medicines with supporting information on "how I take my medicines". 'As needed' sedative medicines prescribed were administered infrequently. Staff managing medicines for people had been trained and their ability to safely administer medicines was monitored.

We will undertake another unannounced inspection to check on all other outstanding legal breaches identified for this home.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Comprehensive Inspection of 1, 2 and 15 October 2014

People were not kept safe at the home.

The management and administration of medicines were unsafe. People were given sedative medication routinely rather than 'as needed', as prescribed by their GP. This meant they were given sedation at times when they did not need it, which placed them at risk of harm.

Safeguarding procedures and training did not make sure that all staff knew and understood when and who they needed to report allegations of abuse to.

Risks were not always identified and managed to make sure people were kept safe.

People's records were not accurately maintained to make sure they reflected the care and support they had received.

Focused inspection of 22 December 2014

Medicines were safely administered and recorded but those requiring refrigeration were not safely kept within their recommended temperature range.

Administration records were complete. Care plans were in place for people prescribed medicines for challenging behaviour along with information about allergies and how a person preferred to take their medicines.

Is the service effective?
(Text unchanged from comprehensive inspection)

Inadequate

Is the service caring?
(Text unchanged from comprehensive inspection)

Requires Improvement

Is the service responsive?
(Text unchanged from comprehensive inspection)

Inadequate

Is the service well-led?
(Text unchanged from comprehensive inspection)

Requires Improvement

Highfield Manor Care Home

Detailed findings

Background to this inspection

This inspection report includes the findings of two inspections of Highfield Manor Care Home. We carried out both inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The first was a comprehensive inspection of all aspects of the service and took place on 1, 2 and 15 October 2014. This inspection identified breaches of the regulations.

The second was undertaken on 22 December 2014 and focused on following up on action taken in relation to the breach of one of the legal requirements we found on 1, 2 and 15 October 2014.

You can find full information about our findings in the detailed key question sections of this report.

Comprehensive Inspection of 1, 2 and 15 October 2014

This inspection took place on 1, 2 and 15 October 2014 and was unannounced. We carried out a planned inspection on 1 and 2 October and returned on 15 October to gather further information. There were three inspectors in the inspection team and two inspectors visited on each date. We met and spoke with all 45 people living at Highfield Manor. Because most people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with six visiting relatives, a visiting social worker, a district nurse, a chiropodist and the hairdresser during the inspection. We also spoke with the registered manager, two deputy managers and five staff.

We looked at five people's care and support records, an additional six people's care monitoring records, all 45 people's medication administration records and documents about how the service was managed. These included staffing records, audits, meeting minutes, maintenance records and quality assurance records.

Before our inspection, we reviewed the information we held about the service. This included the information about incidents the provider had notified us of. We also contacted one commissioner and four health and social care professionals who work with people using the service to obtain their views. We had contact from four different relatives before the inspection who raised concerns with us. We also had contact with four additional relatives following the inspection who also raised concerns with us.

We asked the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they planned to make. However, the provider told us they did not receive the request and did not complete this. We resent our request for this information after the inspection. This information had not been received at the time of us completing this inspection and was not used to inform judgements in this report.

Following the inspection, the registered manager sent us information about policies and procedures, end of life care, survey results, staff training and the training plan.

Focused inspection of 22 December 2014

This focused unannounced inspection of Highfield Manor Care Home took place on 22 December 2014. There were 44 people living at the home. This inspection was done to check that the warning notice we issued after our 1, 2 and

Detailed findings

15 October inspection had been met. The team only inspected the service against one of the five questions we ask about the service; is the service safe? This was because the service was not meeting relevant legal requirements.

There was a pharmacy inspector and the lead inspector for this service in the inspection team. During the inspection we spoke with two people, the three deputy managers and two staff.

We reviewed the Medicines Administration Record (MAR) for 21 people, the medicines sections within care plans for four people, Topical Medicine Administration Records (TMAR) for six people, the medicines policy and seven staff training records.

Inadequate

Is the service safe?

Our findings

Comprehensive Inspection of 1, 2 and 15 October 2014

People who were able to said they felt safe at Highfield Manor. One person said: "I'm comfy and happy here and I feel safe". We saw that other people freely approached and sought out staff. They smiled and responded positively when staff spoke with them. When people were upset or anxious they sought out staff to provide reassurance and comfort. This indicated people felt comfortable and safe with staff. For example, one person called out repeatedly and staff responded to the person's questions, gave them physical comfort and reassured them they were safe. Relatives told us they felt their family members were safe at Highfield Manor. However, we found significant shortfalls in the safety of the service.

We saw medicine stocks and management systems were audited on a monthly basis. We checked the controlled drugs storage and stock management systems in place. We found the stock and the controlled drugs record book balanced for the controlled medicines in use at the home.

The deputy manager responsible for ordering medicines told us they also audited the medication administration records each week. They said if any gaps or omissions were identified they checked against the stock to make sure that the medicine had been administered. They followed up with individual members of staff where gaps were noted. However, these audits were not effective as they had not identified the shortfalls we found.

The deputy manager told us there were nine staff who were trained to administer medicines. Records showed us three of these staff had their competency to administer medicines assessed in February and March 2014. However, six of the staff who administered medicines had not had their competency assessed. This meant that people could not be assured that these staff had the knowledge and skills to administer medication. There was no schedule to determine how often staff competency was going to be reassessed to ensure that staff were able to continue carrying out this task safely.

We looked at the medicines plans, administration and monitoring systems in place for people. People who had PRN (as needed) sedative medicines prescribed were given these medicines routinely rather than when they needed them. These medicines had been prescribed to be given 'as needed' rather than routinely. Therefore people had been given sedation at times when they did not need it, which placed them at risk of harm. There were no 'as needed' medicine plans in place to make clear to staff the circumstances when they should administer these medicines, the maximum dosage and the time between doses. We raised this serious shortfall with the manager and deputy managers on the 1 and 2 October 2014. When we returned on 15 October 2014 we found this practice had continued and people had continued to have sedative medicines on a routine basis. In addition to this, 'as needed' medicine plans were still not in place to advise staff when these medicines should be given.

For some sedative medicines, medication administration records did not detail whether half or a whole tablet had been administered. This meant that a stock balance could not be established and we could not be sure of the amounts that had been administered to the person. One person's sedative medication administration record had been signed for 11 times but there were19 tablets missing from the medicine blister pack. (This is a type of monthly medicine administration dosage packet dispensed from the pharmacy). This meant eight sedative tablets had been removed from the pack, but the records did not state what had happened to this medicine.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there were not appropriate arrangements for the administration, and recording of medicines.

The safeguarding policy was out of date, did not make references to offences under the Mental Capacity Act 2005 and did not include the correct details for the local authority for staff to report any allegations of abuse. Staff had been trained in safeguarding as part of their induction. All of the staff we spoke with were confident of the types of the abuse and how to report any allegations. However, one staff member said they would speak with a staff member if they witnessed them shouting at someone rather than reporting it but if it happened again then they would then report it. This was an area for improvement because the safeguarding policy did not provide staff with the contact information on how to report allegations of abuse and some staff may not have responded appropriately to any allegation of abuse.

People had risk assessments and management plans in place for falls, pressure areas and nutrition. However, there

were no assessments and management plans in place for other risks. For example, two of the three people who had bed rails to minimise the risk of them falling out of bed, did not have a risk assessment completed to ensure that bed rails were appropriate to meet their needs. People who sometimes showed behaviours that challenged others did not have these risks assessed and behaviour management plans were not in place. This meant that staff did not have information about how to manage people's behaviours in a safe and personalised way.

Two of the five people's care records included a personal evacuation plan. For the remaining three people this information was not available, therefore staff and emergency services may not know how to safely support these people in an emergency.

These shortfalls in risk assessments and management plans, and emergency plans were a breach in Regulation 9 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care and monitoring records were not consistently maintained and we could not be sure they accurately reflected the care and support provided to people. For one person daily records were not completed for one night and for another person their name was recorded differently in different records. Three people's fluid records had not been added up to make sure they had enough to drink, and according to the records we saw those people did not drink the target amount recorded on their monitoring records. Two people's weights were inaccurately recorded on their care plans and food and monitoring records. We found an eating and drinking plan for another person in one person's care plan. This was a potential risk because the care plan did not accurate reflect the care and support for this individual.

These shortfalls in record keeping were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and relatives said there were enough staff most of the time. One relative said: "Staff respond really quickly if you ask for help". The district nurse and chiropodist told us there were staff available when they needed them. However, some people gave us conflicting opinions that staff were not available at the times when they wanted support. One person said: "The staff seem to disappear completely in the evenings and you have to get undressed when they say and don't always have choice about what time to get up in the mornings". Another person said: "When I use my call bell at night it can be a while (for staff to arrive)… it feels that we have to adapt to the staff rather than the staff adapt to us".

We observed during the inspection there were enough staff to meet people's needs. The deputy manager acknowledged that additional staff were on duty because of the inspection so managers could be freed up to support the inspection. The number of staff on duty during the inspection did not reflect the usual number of staff working. We looked at the last four weeks' staff rotas and found they reflected the staffing levels the deputy manager and staff told us. Additional staff had been working between 8pm and 10 pm from 8 September 2014. The manager and deputy manager told us this was in response to an increase in people's needs. We explored with the manager and deputy manager how they determined the amounts of staff they needed. However, they were not able to demonstrate how they worked out staffing levels and whether it was based on people's individual needs. This was an area for improvement as they were not able to relate staffing levels to people's needs.

We looked at four staff recruitment records and spoke with one member of staff about their recruitment. We found that recruitment practices were safe and that the relevant checks had been completed before staff worked with people. This made sure that systems were in place to protect people from individuals who were known to be unsuitable.

Focused inspection of 22 December 2014

Medicines were safely kept. We undertook a stock check of a sample of medicines against the records and these were in agreement. Medicines were stored securely within locked medicines rooms or trolleys.

The service had one medicines refrigerator in use. The refrigerator records and refrigerator thermometer indicated the refrigerator had been outside of the recommended temperature range. Temperature records were not kept for the three medicines rooms but a thermometer in one room indicated that the minimum room temperature was above the maximum recommended temperature for the storage of medicines. The deputy managers had undertaken a number of medicine administration audits. However, they had not identified any concerns with the refrigerator

records or taken any action to address this shortfall. Appropriate arrangements were not in place to store medicines within their recommended temperature ranges. This was an area for improvement because the temperature may have affected the effectiveness of people's medicines.

The date when one medicine had been removed from the refrigerator and kept at room temperature had not been recorded. This was an area for improvement so that District Nursing staff were aware of how long the medicine had been out of the fridge and could ensure it was used within the recommended time.

Medicines administration was recorded appropriately. Care plans were in place for people prescribed 'as needed' sedative medicines for when they were upset and presented behaviours that could challenge others. These included minimum dose intervals and the maximum number of doses in 24hours. Supporting information on "how I take my medicines", allergies, and if the person was aware of their needs and could request medicines was also documented.

'As needed' medicines prescribed for when people were upset and presented behaviours that could challenge others were administered infrequently and only following a secondary opinion and review by another deputy manager. The covert administration of medicines had been authorised for one person by their GP, following a mental capacity assessment and best interest meeting with a family member and health and social care professionals. Covert administration is where a medicine is disguised in food or drink when the person does not consent to taking the medicine. Specialist pharmacist advice was also documented on how to administer the medicines covertly and retain the medicines effectiveness. We checked the administration records for one person against the medicines they received and the records reflected the doses that had been administered.

Seven members of staff administered medicines and we saw their training and supervision records to show they had been assessed as competent.

Following our last inspection a deputy manager had met with GPs from the two local practices and people's medicines had been reviewed. The use of 'as needed' sedative medicines had been reduced for most people. These changes in prescribed medicines had been shared with the community pharmacy and the Medicines Administration Records (MARs) were being revised to reflect the prescribing changes.

Inadequate

Is the service effective?

Our findings

(Text unchanged from comprehensive inspection)

Requires Improvement

Is the service caring?

Our findings

(Text unchanged from comprehensive inspection)

Inadequate

Is the service responsive?

Our findings

(Text unchanged from comprehensive inspection)

Requires Improvement

Is the service well-led?

Our findings

(Text unchanged from comprehensive inspection)

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving unsafe or inappropriate care because they had not assessed, planned and delivered the care to meet service user's needs and ensure the welfare and safety of each service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person had not ensured that service users were protected from the risks of unsafe or inappropriate care because they had not maintained accurate records of the care and treatment provided to each service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person did not have suitable arrangements in place to ensure that persons employed for the purposes of carrying on the regulated activity received adequate training, supervision and appraisal.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person did not ensure that service users were protected from the risks of inadequate nutrition and hydration by means of the provision of a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service user's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person did not have an effective system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by service users, or person's acting on their behalf.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

This section is primarily information for the provider

Action we have told the provider to take

Comprehensive Inspection of 1, 2 and 15 October 2014

Service users who used services were not protected from unsafe or inappropriate care because the registered person did not regularly assess and monitor the quality of service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person did not notify the Commission of incidents affecting people living at the home.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person was not protecting service users against the risks associated with the unsafe use and management of medicines. **22 December 2014** The provider is now meeting this regulation

The enforcement action we took:
We have issued the provider with a warning notice relating to the management of medicines. The provider must comply with this regulation by 14 November 2014.