Mrs Gillian Waller

Highmead House

Inspection report

153 Finedon Road
Irthlingborough
Wellingborough
Northamptonshire
NN9 5TY

Tel: 01933650244

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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
Highmead House is a residential care home providing accommodation and personal care for up to 32 people. The service provides support to older and younger people, people living with dementia and people with physical disabilities. At the time of our inspection there were 26 people using the service.

People's experience of using this service and what we found
People's health and safety was put at risk from lack of adequate bathing facilities, maintenance of the premises and infection control risks. Some action was taken to reduce immediate risks but further action was needed.

Risks associated to people's needs had been assessed and care plans had guidance for staff to follow. However, risks to people were not always managed and monitored effectively.

The provider did not have effective oversight systems and process in place to monitor all aspects of the service provision to drive improvements.

People and their relatives felt the service was safe, and people were cared for by staff who understood safeguarding procedures. People were supported with their medicines well.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People lived in a clean environment. There was ongoing decorating within the service.

Staff had been safely recruited. There were enough staff working at the service to keep people safe. Staff were trained for their role, supported by management and received feedback on their performance.

People, their relatives and staff had confidence in the management team. People were involved in the review of their care. Feedback about the quality of service was sought from people, their relatives and staff and used to make improvements.

The service worked in partnership with external professionals. The registered manager shared information and any lessons learnt with the staff team.

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 good (published 29 January 2018). At this inspection we found breaches

of regulation in relation to premises and equipment, risks to people's safety and wellbeing and governance oversight and monitoring.

Why we inspected
This focused inspection was prompted in part by a review of the information we held about this service and concerns received about staff working whilst they had tested positive for Covid-19 and the lack of bathing facilities. A decision was made for us to inspect and examine those risks.

This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

Enforcement
We have identified breaches in relation to premises and equipment, infection prevention and control, people receiving safe care and treatment and governance arrangements.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Highmead House

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 1 inspector.

Service and service type
Highmead House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Highmead House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

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 and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 5 people who use the service and 4 relatives, and observed the interaction between people and the staff. We also spoke with 9 staff. They included the registered manager, deputy manager, care staff and house-keeping staff. We reviewed a range of records. This included 4 people's care records, medication records and 3 staff files in relation to recruitment and supervision. We checked the environment of the home. A variety of records relating to the management of the service, including staff training information, audits, meeting records policies and procedures.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Assessing risk, safety monitoring and management

● Premises and equipment were not adequately maintained or safe to use. There was a lack of adequate and accessible bathing facilities. One bathroom with a bath tub and shower was used to store equipment and was not accessible to people with mobility needs. Another bath with a hoist was intermittently faulty, which meant it was not safe to use. People and their relatives were not aware there was limited bathing facilities and a faulty bath with a hoist. Care records showed some people could only have a strip wash as they could not have their preferred bath or use the shower. This meant people's health was put at risk due to the lack of adequate bathing facilities.

● Radiators in people's bedrooms did not have protective radiator covers. This can cause serious burns if a person's skin comes into contact with the radiator while in use. The metal edging on the radiators could cause serious injury if a person was to accidentally fall onto the radiator. This meant people's health and safety was put at risk.

● Lack of effective maintenance put people's safety at risk. Free-standing bedroom wardrobes were not secured to the wall. This meant the person in that bedroom was at serious risk of injury if the wardrobe was to fall. The blinds covering the polycarbonate roof panels in the dining room had fallen away and windows were not covered to reduce direct sunlight entering this area which people used. This meant people using this area were at risk from the heat and potentially sun burn.

The provider had not ensured people and others were protected from the risks associated with unsafe or unsuitable premises because of inadequate facilities and maintenance. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's identified risks were not always managed or monitored. Where people were at risk of developing pressure sores, pressure relieving equipment was in place. However, records showed staff had re-positioned a person at regular intervals but did not always record the change of position. This increased the risk of skin damage if the person remained in same position for an extended period of time. A person's fluid intake was monitored due to risk of dehydration. They were to be encouraged to consume up to 1200mls per day to maintain good health. Staff recorded the intake but this was not monitored and no action had been taken by staff when the person had not drunk enough. This put people at risk of dehydration and increased risks due to the warmer days.

● New risks were not always identified or managed. Some people were sat in the garden area on a hot day but not everyone was in the shade and protected from the direct sun. No one wore hats and sunscreen had not been applied. This meant people were at risk of sunburn and skin damage.

The provider had not ensured risks associated with people's care had been managed and monitored effectively. This was a breach of regulation 12, (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe living at the service. A person said, "There's staff around and I only need to use this [call bell] if I need anything." A relative also said their family member was safe.
● Risks associated with people's individual physical and mental health needs had been assessed. For example, where someone was at risk of falling, a detailed personalised plan including equipment to be used, was in place to mitigate risks. We saw staff supported people safely to move around using equipment correctly.
● Regular fire safety and emergency light checks carried out to promote safety. Personal emergency evacuation plans provided staff with guidance of how to safely evacuate people in an emergency.

Preventing and controlling infection
● The provider had not always ensured people living at the service and visitors were protected from the risk of spreading infectious diseases. The registered manager told us a member of staff had worked after they had tested positive for Covid-19 and appropriate risk assessment and measures were put in place. Although no-one was harmed, the government guidance and the provider's infection prevention and control policy had not been followed in this case.
● People were not protected from the risk of infectious diseases. Bottles of water had been place next to the toilets in people's ensuite rooms and the communal bathroom. Neither staff nor management knew their purpose but housekeeping refilled the bottles daily. This meant people were at risk of cross contamination and ill health if they handled or drunk the water from the bottle.
● Porous surfaces were found which increased the risk of spreading infectious diseases. There were exposed wooden door and handrails throughout the service, the bathroom with the hoist had missing tiles and there was exposed plaster, brickwork and flooring in the dry food and freezer rooms.

The provider had not ensured people were protected from the risk of infectious diseases. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities).

● The registered manager was responsive and took action to reduce some risks. For example, they removed the bottles of water next to people's toilets and arranged for doors and exposed brickwork to be painted using material that complied with fire and health and safety requirements.
● All areas of the service were clean. Housekeeping staff followed cleaning schedules.
● We were assured the provider was admitting people safely to the service.
● We observed staff using PPE effectively and safely.
● Staff were aware of the risks and signs of infection. People had access to Covid-19 tests and were encouraged to remain in their room where possible to reduce the risk of spreading infections.

Visiting in care homes
● People were supported to maintain contact with their family and friends. Visits to the service were well facilitated. People and relatives raised no concerns about visits.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe with the staff and the care provided. A relative said, "[Name] seems happy, and well. I don't have any concerns and [Name] hasn't told us there's been any problems."
● Staff were trained in safeguarding procedures. A staff member said, "I know what abuse is but never seen anything happen here. I would report everything to my manager, from any unusual marks to other types of

abuse. They would investigate. I wouldn't hesitate to inform the authorities if I need to."
● When safeguarding concerns were identified they were managed by the registered manager. Appropriate referrals to the local authority and CQC were made in a timely manner.

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

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● The registered manager understood their duties under the MCA. There was appropriate paperwork and assessments in place to ensure where decisions were made in people's best interest this was done legally.

Staffing and recruitment
● People told us they were happy with the staff and our observations confirmed there were enough staff on the day of inspection to meet people's needs safely. A relative said, "Staff always pop in to see [Name], have a chat and [Name] loves being fussed over."
● The registered manager demonstrated how they looked at people's individual needs to establish how many staff were required on each shift.
● Safe staff recruitment processes were followed. Staff files contained relevant pre-employment safety checks and included Disclosure and Barring Service (DBS) checks, to ensure they were suitable to work within the home.

Using medicines safely
● People were happy with the support they received with their medicines. A person said, "[Staff] brings my tablets and it's one less worry for me to have to remember everything."
● We observed a medicines round. Medicines were administered at the right time by staff trained and assessed competent to do so. This included medicines prescribed 'as and when required' (PRN) medicines, such as pain relief. Staff followed the protocols and people were asked if they required any PRN medicines. Medication administration records we checked had been completed fully.
● Medicines were stored and disposed of in a safe way. Regular audits and checks were carried out by the deputy manager to ensure medicines management was safe.

Learning lessons when things go wrong
● Staff knew how to report and record accidents and incidents when they occurred. These were analysed individually and any lessons learnt from such events were shared with the staff to improve people's safety.

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 last inspection we rated this key question good. At this inspection the rating has changed 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

- Since the last inspection, there was new registered manager. The registered manager was not fully aware the responsibilities to notify CQC of certain incident and events such as the issues within the premises. They did submit a notification to CQC after we raised it with them.
- There were limited systems in place for monitoring the quality and safety of people's care. systems. Where audits were in place these were not effective, for example the infection control and environmental checks were completed but this had not enabled the provider to identify the safety issues we found. People's care and their care records were not always monitored to identify any health concerns or recording issues.
- Training was not monitored to ensure staff had the required skills to meet people's needs. For example, only 1 staff member had been trained in catheter care and no staff had completed the learning disability and autism training. This put people at risk of receiving inappropriate and unsafe care and support.
- There was limited oversight of incidents, accidents, complaints and safeguarding concerns. Whilst these were logged individually, the provider did not have effective systems in place to identify patterns and trends in concerns. A person had a wound on their leg and was under the care of the community nurse. From reviewing the care records, incident form and speaking with staff and management, it was unclear how or when the injury occurred. The lack of investigation into individual incidents and oversight meant people's safety was put at risk.
- The registered manager told the provider visited the service but there were no records of these visits, areas identified for improvement or how progress towards these were being monitored.

The provider's oversight systems and processes had not been fully implemented to monitor all aspects of the service and to mitigate risks to people's safety and provide a safe service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager took some immediate action in relation to staff training and requested external professionals to complete a full infection control audit.
- Some audits such as medicines management and fire safety checks were used effectively. The provider was investing in the service. The installation of a new call bell system had been planned to improve people's safety and improve management oversight.
- People, relatives and staff were confident any concerns raised would be taken seriously. A staff member said, "[Deputy manager] and [registered manager] are supportive. If we're concerned about anyone [deputy

manager] will check them."

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

● People and relatives spoke positively about the staff and the management. A relative said, "It's not a fancy big modern care home but the care is good and staff are very kind and caring."

● Staff were responsive when people's needs changed and promoted good outcomes by encouraging people to remain as independent as possible. Care plans were personalised and reflected people's routines, preferences and what was important to them. Staff knew the people well and understood how to support them in line with their preferences and wishes.

● Staff worked as a team, understood their responsibility and were committed to caring for people.

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 registered manager was clear about their responsibility to be open and transparent in line with their duty of candour responsibility. We saw examples of action taken by the registered manager, which had been clearly communicated.

● People, staff and relatives told us they knew how to complain. Where issues had been raised these were recorded in people's electronic care records including the actions taken.

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

● Staff felt supported in their role, received feedback on their performance through supervisions and attended staff meetings which were informative.

● Systems were in place to ensure people, relatives and staff had opportunities to give feedback on the quality of care and service through individual and residents' meetings and surveys. One person said, "I've been to meetings with other residents to talk about what's happening here, food choices, staff changes and if anyone has any concerns." A relative told us they visited regularly and if they had any concerns they would speak with the registered manager. A sample of the completed surveys seen were positive.

Working in partnership with others

● Feedback received from the local authority which monitored people's package of care, was positive in relation to the quality of care provided to people and response to concerns.

● Staff worked in partnership with other agencies and health care professionals. Records showed people had been referred to health care professionals when required to promote people's health and wellbeing.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks associated with people's care had been identified, mitigated and monitored. The provider failed to ensure people were protected from the risk of infection. Regulation 12 (1) (2) (a), (b), (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's oversight systems and processes was not fully implemented nor used effectively monitor and mitigate risks to people's safety and provide a safe service. This placed people at risk of harm. Regulation 17 (1) (2) (a), (b) (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 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1)

The enforcement action we took:

We issued a Warning Notice.