Accommodating Care Newent Limited

Highfield Residential Home

Inspection report

Culver Street
Newent
Gloucestershire
GL18 1JA

Tel: 01531821007

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16 December 2015

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 27 February and 2 March 2015 where we found breaches of regulations in relation to management of medicines, deprivation of liberty, staff recruitment procedures and notification of incidents. We checked and found the breaches had been met at an inspection on 7 July 2015. After that inspection we received concerns in relation to food, drink and nutrition, how people spent their time and the management of laundry. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those/this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

We found some people were not adequately supported with their nutritional needs. In particular people who required individual support and monitoring. A thickening agent to help prevent one person choking on fluids was not available in the care home.

Although we received concerns about people's beds being left with dirty bedding we did not find this was the case, beds we examined were made with clean bed clothes. There was a lack of guidance for staff in relation to the correct temperatures to wash laundry. We passed information about food storage issues to the local authority.

People did not always receive the support they needed to take part in activities of their choice.

Highfield Residential Home did not have a registered manager. A manager had recently been appointed although at the time of our inspection visit we had not received an application from them to be registered as manager for Highfield Residential Home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

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

The service was not fully safe.

Although we found people had clean bed linen, there was a lack of guidance for staff about the required temperatures to wash laundry to prevent cross infection.

We could not improve the rating for safe from inadequate because to do
so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service effective?

Requires Improvement

The service was not fully effective.

Some people were not fully supported and monitored to maintain their well-being through adequate nutrition.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

People did not feel able to take part in some activities because of a lack of support.

Highfield Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 December 2015 and was unannounced. We started the inspection at 6.45am in response to the information we had received. The inspection team consisted of two inspectors. We spoke with four people using the service, the manager and five members of staff. We reviewed records for seven people using the service.

Inadequate

Is the service safe?

Our findings

We received information about people's beds being left with dirty bedding and soiled laundry was not being washed at the correct temperature.

People were sleeping in clean bed linen although there was a lack of guidance for staff about correct laundry washing temperatures. We checked eight beds, which had been made up. All were seen to be clean. We also saw two beds which were stripped, ready to be made. A member of staff told us most beds were stripped and changed daily.

We found the laundry had been maintained in a tidy and organised state. We asked a member of staff what temperature soiled laundry would be washed on and they indicated one of the higher temperatures on the washing machine setting. However there was no information in the laundry to direct staff to the required temperature setting for different laundry loads. We discussed this with the manager who agreed to rectify this.

We found issues with a lack of dating of food in the refrigerator in the kitchen. This was despite a sticker on the refrigerator door reminding staff to date food items. We shared this information with the local authority responsible for food hygiene inspections.

Requires Improvement

Is the service effective?

Our findings

We received information about people not being given drinks, not eating an adequate diet and shortages of a thickening agent for people at risk of choking.

Some people were not fully supported and monitored to maintain their well-being through adequate nutrition. Weight monitoring was in place for people identified as being at risk of weight loss. However weights had not been recorded as directed and malnutrition assessment tools, although present in people's care documentation, had not been completed. One person's weight chart stated "weigh every two weeks" however they had not been weighed since November 17 2015. Another person had the same directions on their weight chart although they had not been weighed since 1 December 2015. Another person had a weight chart although no recording of their weight had been completed.

People had their food and fluid intake monitored and recorded although the majority of records we saw had no dates recorded which limited the value of the record as a monitoring tool. For example one person's records were only dated on 28 November 2015 and 12 December 2015. Records for another person were only dated for the 12 December 2015. We were told people's GPs were aware of their weight loss although there was no recording in care plans to support this. Care plans were available for recording information about people's care including their nutritional support. However there was a practice of recording information in a communication book used by senior care staff. This would not enable clear evaluation of people's care to take place when individual information was not easily available to retrieve.

Two people had been identified as requiring thickening agents in their drinks due to their risk of choking. We checked stock levels of the thickening agent for these people. One person had adequate stocks. However another person had none and had been without this for at least three days. Staff were aware of this although this had not been brought to the manager's attention. We raised the issue with the manager who arranged for this to be rectified as soon as possible through contact with the GP. The person's care plan did not reflect the use of the thickening agent in their drinks.

People who required assistance with eating did not receive adequate attention from staff. We observed one person experienced a delay of 20 minutes before they received their breakfast despite repeatedly asking for this. They required assistance with eating their breakfast with their care plan stating "I eat my breakfast in the chair with the help of a carer". One person who had been feeling unwell was struggling to eat their lunch. We observed they ate and drank very little. They were not offered an alternative to the meal provided. Four people required assistance with eating their lunch but did not have a dedicated person who stayed with them throughout the meal to provide consistent support and monitoring.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we arrived at the care home, a member of staff told us that the member of staff in charge was "just giving someone a drink". Staff told us that people who had recently received personal care had also been

given drinks. We noted a jug of water and a beaker was available in one person's room. We observed communal areas and noted that the first person brought into the communal lounge by staff was promptly given a cup of tea. They commented "nice cup of tea, very welcome". This was followed a little later by breakfast including fruit juice and a pot of tea. The person told us the meals were "fine" and they had "no complaints".

We spoke with people about the meals provided and received mixed feedback. We observed lunch being served to people and heard comments such as "That was tasty, I thoroughly enjoyed it" and "I enjoyed that, thank you". However when we spoke with people individually we heard comments about the meals such as "not up to much", "alright, nothing special". On the day of our inspection lunch was beef stew, broccoli, cauliflower and mashed potato with banana cake and custard for dessert. One person who ate a vegetarian diet was provided with a vegetarian lasagne. Large portions were provided and there was little waste.

We received information about food items stored in the refrigerator in the kitchen not being dated. We were shown the food store where fresh ingredients were available for the preparation of meals. Where people had received input from speech and language therapists for a choking risk, this was recorded in their care plans.

Requires Improvement

Is the service responsive?

Our findings

We received information about people being isolated in their rooms and a lack of choice about how some people spent their day.

Although people told us they were satisfied with how they spent their time, we found there were some limitations on their choice of activity through a lack of support. We spoke with some people who spent the majority of their time in their individual rooms. One person told us they were "quite happy" spending time in their room where they were able to follow their own interests. They told us they were able to come and go as they pleased and told us of two recent trips out of the care home. Another person told us they liked spending time in her room because "if I go downstairs I just sit, I can do that here". However they were also reluctant to sit in one of the downstairs lounges and explained the reason for this. "I get left"…they don't bring me up when I want-" and "I would go down to play bingo as long as I could come back up, when I wanted". Despite this they confirmed they were able to do as they wished in their room and could keep in touch with the outside world through the television and their telephone.

Another person we spoke with was quite happy to spend time in the lounge area with other people and sit in the dining area for their meals. However they did comment they would like more freedom to come and go as they pleased, such as to go out into the garden. They also said "it's dull here".

We received information about laundry not being sorted appropriately and residents sharing clothes. People's individual clothes were organised into named baskets for return to their room once they had been laundered. We observed a member of staff taking a person's clothes to their individual room. The manager was not aware of any examples of people sharing clothes.

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 RA Regulations 2014 Person-centred care People were not fully supported or monitored to maintain their well-being through adequate nutrition.