H G M MEXBOROUGH LLP

Highgrove Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

We last carried out a full inspection of this service on 3 and 5 February 2015, during which we found a number of breaches of regulation. We gave the location an overall rating of inadequate following that inspection. The inspection of 18 June 2015 took place to look at whether any improvements had been made since the previous inspection.

This report only covers our findings in relation to this topic. You can read the report from our last inspection by selecting the 'all reports' link for Highgrove Care Home on our website at www.cqc.org.uk

We undertook this focused inspection to determine people experienced a service which was well led and effective.

Highgrove Care Home is located in the Doncaster suburb of Mexborough. It is known locally as Highgrove Manor.

The home is purpose built and set in its own grounds with parking facilities. The home is divided into four separate units, although at the time of the inspection one of the units was not in use.

The home had not had a registered manager in post for over a year, despite one being required. There was a new manager in post, but they had not yet applied to be registered with the Care Quality Commission. A 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.

At this inspection we identified a number of concerns. We found breaches of the Health and Social Care Act 2008

Summary of findings

(Regulated Activities) Regulations 2014 in that people did not receive care which met their needs, and the systems in place to monitor and assess the quality of the service were not always effective.

We found that the arrangements in place for obtaining consent, and acting in accordance with people's consent, were poor, and the provider had failed to take the steps they were legally required to take in relation to this.

The provider had developed a range of audit tools, and appointed an external consultant to assist them in improving the service. However, we identified that the audits were not always effective, or were not carried out at their intended frequency. The provider had failed to have regard to concerns identified by the external consultant some months earlier.

Staff we spoke with told us that staffing numbers had recently increased, and they felt they were better supported to do their job and provide care. However, we found that some staff had not received training in key areas, including consent and mental capacity, and safeguarding of vulnerable adults.

We saw that the provider had made some environmental improvements and was undertaking a refurbishment programme, although this had not yet been completed, and some bathrooms were still in a poor condition.

We are taking action against the provider, and will report on this at a later date.

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 effective?

The service was not effective. Staff had not received all the training they required, and at times communicated with each other in a way that did not uphold people's rights to privacy or dignity.

The arrangements in place for gaining and acting in accordance with people's consent were poor. Where people lacked the capacity to consent to their care and treatment, the correct legal procedures were not always followed.

Inadequate

Is the service well-led?

The service was not well led. The provider had not implemented the improvements it had told the Care Quality Commission it had made.

There were systems in place to audit people's care and the quality of the service. However, these systems had not identified shortfalls in the way people's care needs were assessed or recorded, and had not recognised where improvements were required in relation to staff training or the condition of the premises.

Inadequate

Highgrove Care 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 to determine people received effective care, and whether the service was well led. We inspected this service against two of the five questions we ask about services; is the service effective; is the service well led?

This inspection took place on 18 June 2015 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before our inspection we reviewed information we held about the service. The provider had not completed a provider information return (PIR) as we had not requested one. The pre-inspection information pack document is the provider's own assessment of how they meet the five key questions and how they plan to improve their service. We checked records we hold about the service, and checked information that the provider had supplied to the Commission, setting out how they believed they had improved the service. We also held a meeting with the provider earlier in the year in which they told us about their planned improvements.

At the time of our inspection there were 45 people living in the home.

We carried out a physical check of the premises, including some people's bedrooms, communal bathrooms and lounge areas. We spent some time looking at documents and records that related to people's care, including care plans, risk assessments and daily records. We looked at seven people's support plans, and checked records relating to consent and capacity for a further eight people. We checked records relating to the management of the home, staff files and training records, and records relating to how the service was audited. We spoke with four people living at the home about their experience of receiving care. In addition to this, we undertook a Short Observation 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 also contacted the local authority to gain their view of the service provided.

During our inspection we also spoke with six members of staff, which included care workers, nursing staff, catering staff and members of the provider's management team.

Inadequate

Is the service effective?

Our findings

People we spoke with who were using the service at the time of the inspection gave us a positive picture of their experience of life at Highgrove Care Home. One person told us they liked watching staff going about their duties, and another told us the staff were "very kind." However, in our observations we found that staff did not always interact positively with people. For example, during breakfast we observed one person who was speaking to a staff member, asking them if they were all right. The staff member was standing next to them but did not respond. Another staff member was observed to take a person away from their unfinished breakfast without asking them whether they had finished their food, or whether they wished to leave the room.

We asked people using the service about the food they received. They told us they enjoyed it and that it was plentiful. We spoke with a member of the catering staff who knew people's dietary needs and preferences well. These were also well documented in the care plans we looked at.

We checked whether people had given appropriate consent to their care and where people did not have capacity to consent, whether the requirements set out in the Mental Capacity Act 2005 had been adhered to. The Mental Capacity Act 2005 sets out how to act to support people who do not have the capacity to make a specific decision, and also sets out the legal framework in which a person who lacks capacity can be deprived of their liberty.

We found that the arrangements in place for obtaining and acting in accordance with people's consent were poor. For example, one person's support plan recorded that they were unable to make any decisions about their care. However, an assessment within their records recorded that the person had variable mental capacity and was able to make some decisions. Another person's records stated that they did not have the mental capacity to make decisions about their care, but all decisions had been made by the home's manager, rather than consulting with people to reach "best interest" decisions as required by the Mental Capacity Act. One person lacked the mental capacity to make decisions about their care, but their records indicated their consent had been sought and obtained in relation to the provider using their photograph.

In relation to the closure of one of the units within the home, we checked records relating to how people were consulted about this and how decisions were made. We found that this had not been carried out appropriately. One of the people who moved had assessments in their file that concluded they could not make decisions about their care. However, the assessment in relation to whether they could make decisions about moving concluded that they understood and consented to this action. Another person who moved had been assessed as having the mental capacity to make decisions, but there was no evidence they had consented to their move. One file we checked showed that the person was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. The DoLS authorisation had been made because the person did not have the mental capacity to make decisions about their care. However, their records showed that this person had given consent to moving from the closed unit to another one. One person's file contained an assessment about whether they could make decisions about "information sharing." This assessment concluded that they could. A senior manager told us that this referred to the move, although there was no evidence that it did, and records about decision making should be specific and detailed. When we gave feedback about this to the registered person, they described the decision making process in relation to the move as "lip service."

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at assessments about the care and support that people needed, and input by external healthcare professionals. We found that, on occasion, guidance from external healthcare professionals was not being followed. For example, two of the people we looked at had been assessed by external professionals in relation to trying to reduce the number of falls they were experiencing. In both cases, the assessments concluded that the people concerned should be checked at regular intervals, and sensors should be put in place to alert staff if they fell. None of these actions had been taken.

The registered person told us that all service users were weighed weekly. We asked about the arrangements for obtaining people's consent to this, but they told us that this had not been done. We checked one person's weight record which showed that two months earlier they had lost weight and had been assessed as severely underweight.

Inadequate

Is the service effective?

Further records were submitted to the Commission following the inspection, which indicated that this person's weight was being monitored using measurements of their arm circumference, however, these measurements were not taken on a weekly basis.

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

We looked at staff training records, and found that some staff required training in key areas such as mental capacity and safeguarding. We asked the registered person about this. They told us that a training programme had been implemented , and further training was planned for the week after the inspection. The provider acknowledged that some staff had not yet received the training they required.

Inadequate

Is the service well-led?

Our findings

The home had a new manager who had been in post for five weeks at the time of the inspection. They were being supported by the provider's managing director, who was also present during the inspection. The home's manager described that they were not in a position at the time of the inspection to be in overall control of the home, and said that they were currently assisting the managing director in running the home.

There was a range of audits in place, which looked at areas including care records, the environment, medication and the quality of service provided. We checked a sample of recent audits, and checked them against our findings and observations. We found that the audits did not accurately reflect the home's performance. For example, the most recent medication audit recorded that all bottles had dates recorded showing when they were opened, and that medication had been stored at the correct temperature, but we found that this wasn't the case. The provider's "Monthly Visits" audit recorded that everyone using the service had their weight checked every week, but this wasn't happening, and the environmental audit had not identified that some bathrooms were damaged and in need of repair.

Each audit we looked at had a frequency recorded, showing how often the provider intended to undertake it. We found that audits were not happening at the prescribed frequency. We saw documents relating to monthly inspections of the condition of the premises, however, although these were intended to be undertaken on a monthly basis, the records made available to us showed only two had been undertaken that year. The provider subsequently told us that further checks had been undertaken which were not made available to the inspection team during the inspection, however, they acknowledged that there were, nevertheless, some gaps in the audit schedule. We discussed the failures of the audit system with the registered person on the day of the inspection, and they told us they planned to obtain training for certain, nominated staff to enable them to improve the quality of auditing. It was not clear why the provider had not previously identified that the audit system was ineffective.

As a response to the findings of the inspection in February 2015, the provider engaged in the services of an external consultant to support them in improving the quality of service provided in the home. The consultant undertook an assessment in February 2015, and identified areas that needed to be addressed. One area was the lack of appropriate arrangements in place for obtaining, and acting in accordance with, people's consent. However, we found that the provider had failed to have regard to these findings as the arrangements in place in relation to consent remained inadequate.

As part of their programme of improvements, the provider had implemented an electronic system of care planning and storage of care records. Staff told us they thought this was more effective and welcomed it. However, when we checked people's records, we found contradictory and incomplete information. The provider had failed to address this or take the steps required to improve the quality of the records.

Following the inspection in February 2015, the provider told CQC that it had identified that the culture of the service needed to be improved, and that this would be addressed through staff supervision and mentoring. We looked at records of supervision and found that its implementation had been varied. The new home manager told us they were just commencing a programme of staff supervisions, but records showed that this was not yet embedded. Additionally, not all supervisions could be easily evidenced as some staff kept their own records, meaning that the central register was not accurate. It was not clear how the provider audited whether supervisions were taking place or were effective when the records were not accurate.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked incident records, and identified that the provider had failed to make certain, legally required, notifications to the Care Quality Commission. For example, where people had suffered injuries, or where suspected abuse had occurred. The home's manager told us about one such incident which they said they had referred to the local authority's safeguarding team. They told us that they did not think it needed to be notified to the Care Quality Commission as the local authority had assessed the incident and concluded that it did not meet the threshold of abuse. This is not the correct procedure, and this issue has been raised with the provider by CQC on a previous occasion.

Inadequate

Is the service well-led?

This was a breach of Regulation 18 Health and Social Care Act 2008 (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.