H G M MEXBOROUGH LLP

Highgrove Care Home

Inspection report

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Mexborough
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23 September 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place over two days; 21 September and 23 September 2016, and was unannounced. We last inspected the service in February 2016, where concerns were identified in relation to how the provider ensured people were cared for safely; how the provider ensured they were acting in accordance with the legal requirements around consent; and the provider's arrangements for ensuring it provided an effective and well managed service. At that inspection we rated the service as Requires Improvement.

Highgrove Care Home is a 78 bed nursing home, providing care to older adults with a range of support and care needs. At the time of the inspection there were 31 people living at the home. The home is divided into four discrete units, although the provider had stopped using two of the units and therefore only two were in use at the time of the inspection.

Highgrove Care Home is located in Mexborough, a small town in Doncaster, South Yorkshire. The home is known locally as Highgrove Manor. It is in its own grounds in a quiet, residential area, but close to public transport links.

At the time of the inspection, the service had a registered manager. 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 and associated Regulations about how the service is run.

Staff interacted with people warmly and with respect. People's privacy and dignity was upheld when staff were carrying out care tasks. Care plans were devised in such a way as to ensure that good care was supported effectively. Where people's health needs changed, the provider responded promptly, engaging external healthcare professionals and altering the way people were cared for, as required.

There were effective systems in place to reduce the risk of abuse and to assess and monitor potential risks to individual people. Recruitment processes were safe and we saw there were sufficient staff on duty to meet people's needs.

The provider had appropriate arrangements to make sure people received their medications safely, although some improvements were required. We also noted that some staff needed to make improvements to their hygiene practices.

People told us they enjoyed their meals at the home, and our observations corroborated this. People's nutrition and hydration were closely monitored to ensure they maintained good health.

The provider had appropriate arrangements in place to ensure that it adhered to the requirements of the Mental Capacity Act 2005

There was a comprehensive programme of activities, both in the home and within the community.

There were thorough systems in place for auditing the service, to ensure that people received care which was safe and of a good quality.

Staff told us they felt well supported to undertake their roles, although the provider's formal supervision programme was not yet fully embedded.

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 safe, although we identified some areas where improvements were required.

There were effective systems in place to reduce the risk of abuse and to assess and monitor potential risks to individual people. Recruitment processes were safe and we saw there were sufficient staff on duty to meet people's needs.

The provider had appropriate arrangements to make sure people received their medications safely, although some improvements were required.

We noted that some staff needed to make improvements to their hygiene practices.

Is the service effective?

Good

The service was effective

People told us they enjoyed their meals at the home, and our observations corroborated this. People's nutrition and hydration were closely monitored to ensure they maintained good health.

The provider had appropriate arrangements in place to ensure that it adhered to the requirements of the Mental Capacity Act 2005

Is the service caring?

Good

The service was caring.

Care plans were devised in such a way as to ensure that good care was supported effectively.

Staff interacted with people warmly and with respect. People's privacy and dignity was upheld when staff were carrying out care tasks.

Is the service responsive?

Good

The service was responsive.

There was a comprehensive programme of activities, both in the home and within the community.

Where people's health needs changed, the provider responded promptly, engaging external healthcare professionals and altering the way people were cared for, as required.

Is the service well-led?

Requires Improvement

The service was well led, although the management team were in the process of implementing further improvements.

There were thorough systems in place for auditing the service, to ensure that people received care which was safe and of a good quality.

Staff told us they felt well supported to undertake their roles, although the provider's formal supervision programme was not yet fully embedded.

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 planned to check whether the provider was 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. The home was previously inspected in February 2016, where three breaches of legal requirements were identified.

The inspection was unannounced, which meant that the provider and staff did not know that the inspection was going to take place. It took place over two days, 21 September and 23 September 2016. The inspection was carried out by two adult social care inspectors and a pharmacy inspector.

To help us to plan and identify areas to focus on in the inspection we considered all the information we held about the service, including notifications submitted to CQC by the provider and information from other agencies.

At the time of our inspection there were 31 people using the service. We spoke with people who were using the service to gain their views about the care they received. We also spoke with staff members, the registered manager and a member of the provider's senior management team.

We observed care taking place in the home, and observed staff undertaking various activities, including handling medication, supporting people to eat and using specific pieces of equipment to support people's mobility. 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 looked at the care records for five people using the service and records relating to the management of the home. This included meeting minutes, medication records, staff recruitment and training files and surveys completed by people's relatives. We also reviewed records used to monitor the quality of the service provided and how the home was operating.

Requires Improvement

Is the service safe?

Our findings

We asked two people using the service whether they felt safe at the home; they told us they did. We observed staff assisting people in a safe way. For example, we observed two staff assisting a person to move from one area to another using a mechanical hoist. They did this in a safe manner, ensuring that they reassured the person and explained what they were doing and why.

We spoke with staff who displayed a very good understanding of people's needs and how to keep them safe. They spoke with knowledge about risks people may be vulnerable to or may present, and what action to take if necessary. Records we checked showed that staff were undertaking appropriate safety checks where required.

Care and support was planned and delivered in a way that promoted people's safety and welfare. We checked care plans to look at the quality and detail of risk assessments. Overall these had been reviewed and updated when necessary. One person's records showed that they presented very specific risks. Their care records contained a high level of detail setting out what staff needed to do to address these risks, and there was evidence that staff were adhering to this.

We checked the use of bed rails in the home, and noted that their use was not always adequately assessed. Bed rails are a form of restraint, and can cause injury or even death if not used correctly. As such it is imperative that their use is closely monitored. we made reference to this in the written feedback given to the provider on the day of the inspection, and saw that the provider took steps during the inspection to improve the way the risk of bed rails was assessed.

Policies and procedures were available in relation to keeping people safe from abuse and reporting any incidents appropriately. Records within the home, and those held by CQC, showed that the provider had acted appropriately where untoward incidents or suspected abuse had taken place, and appropriate referrals to the local authority had been undertaken.

Our observations indicated there was enough staff on duty to meet people's needs in a timely manner and keep them safe. We asked two staff about this and they told us that staffing numbers had improved recently, and that they felt less rushed, which enabled them to keep people safe.

We checked a sample of staff files which showed that a satisfactory recruitment and selection process was in place. The staff files we sampled contained all the essential pre-employment checks required, including a work history, evidence of identification and references. This also included Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

We checked the arrangements for managing medicines at the home. We looked at medication administration records (MARs) for seven people during the visit and spoke with the assistant manager, a

nurse, and two senior carers who were administering medicines.

The rooms used to store medicines were secure, with access restricted to authorised staff. Room temperatures were monitored daily to ensure they remained within recommended limits. Waste medicines were disposed of in accordance with the relevant regulations. There were appropriate arrangements in place for the management of controlled drugs, including storage and record keeping, and regular balance checks had been carried out. Medicines which required cold storage were kept securely in a medicines fridge in the downstairs treatment room. Fridge temperatures were recorded daily in accordance with national guidance.

People using the service had photographs and allergy details completed on their MARs; this helps to prevent medicines being given to the wrong person or to a person with an allergy. All of the MARs we reviewed had been completed accurately to show the medicines people had received. We checked the stock balances of medicines in the trolleys and store cupboards and found they were correct. Staff routinely recorded the number of tablets given from variable dose prescriptions. Body maps were routinely used for topical treatments and pain relief patches to ensure they were applied to the correct area.

Staff did not follow written information on how to give some medicines which must be taken at a specific time or in a specific way. For example, one person was prescribed a medicine to treat nausea and vomiting. Whilst the senior care worker on duty knew the person well and could tell us when and how the medicine should be given, there was no supporting written information to guide staff who may not know the person.

There was also a lack of information to guide care staff how to give some medicines which must be taken at a specific time or in a specific way. For example, one person was prescribed a tablet for strengthening the bones which should be taken first thing in the morning 30 minutes before food or drink or other medicines. We saw this medicine had been given along with their other medicines after the person had eaten their breakfast. We reviewed records for four people who were prescribed when required laxatives and found in three cases there was no stool chart or monitoring of their bowel habit to guide staff whether laxatives may be required.

The assistant manager carried out monthly medicines management audits. We reviewed two recent audits and saw clear outcomes and actions had been recorded where improvements were needed. Staff had received recent training in medicines management and had had their competency assessed by the deputy manager.

We observed staff carrying out duties during a mealtime in the home, and noted that they did not always adhere to good hand hygiene practice. For example, one staff member was assisting someone to eat and we observed them handle the person's food directly. They did this after their hands had been on furniture and people's clothing, and had not used hand sanitiser or washed their hands in between tasks. Another staff member who was carrying people's food was observed to regularly have their hands in contact with food, but was also touching their own hair as well as furniture and equipment, again without hand washing between tasks.

Good

Is the service effective?

Our findings

We asked three people using the service about the food available in the home. They all told us they enjoyed the food, and said it was plentiful. One person said: "It's very nice." Another told us they had lots of choices and always ate the food they enjoyed.

We carried out an observation of lunchtime in the home. We saw that there was a pleasant, calm atmosphere in the dining room we were observing. People were given appropriate support to eat if they required it, and equipment was available where required. Staff provided people, where needed, respectful and discreet support to eat their meals. Staff mostly took time to ensure people were offered choices of food and drink, although we noted that their choices were anticipated on occasion, for example where staff appeared to believe that they already knew what the person would choose.

We checked five people's care records to look at information about their dietary needs and food preferences. Each file contained details of people's nutritional needs and preferences, including screening and monitoring records to prevent or manage the risk of poor diets or malnutrition. Records were kept of people's food and fluid intake where they were at risk of dehydration or malnutrition. Where people needed external input from healthcare professionals in relation to their diet or the risk of malnutrition, appropriate referrals had been made and professional guidance was being followed.

We looked at records in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). 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 Act 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

At the time of the inspection, ten people living at the home were being lawfully deprived of their liberty. The management team had a thorough oversight of this, and could speak with knowledge about conditions attached to DoLS authorisations, and the duration of authorisations. There were systems in place to ensure that the progress of applications were monitored, and that conditions were complied with.

We also checked people's files in relation to decision making for people who are unable to give consent. The Mental Capacity Act 2005 sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. We found that improvements had been made in relation to decision making for people who lack capacity since the inspection of February 2016, and in most cases the requirements of the Mental Capacity Act were adhered to. However, we noted some areas where improvements were required. For example, one person who lacked capacity had a record in their care plan stating that it was in their best interests for a door sensor to be used. This had been signed by one staff

member and there was no evidence how the decision had been reached that this was in the person's best interest. Another person's file showed that they lacked the mental capacity to give informed consent, but records indicated that they had given consent to their care and treatment. We discussed this with the management team during the inspection, and they described that improvements in this area were part of an on going programme. This was corroborated by the fact that other people's files contained evidence of appropriate best interest decision making where appropriate.

We checked staff training records and saw that staff had received training covering the needs of older people, including training in moving and handling, dementia awareness and safeguarding.

Good

Is the service caring?

Our findings

Our observations showed that staff spoke to people with warmth and respect. Staff we observed appeared to know people extremely well, and spoke with them in a kind and patient manner. Throughout the inspection we saw that staff strived to ensure the environment in the home was calm and peaceful, and responded to people promptly whenever they needed assistance or support.

To assess the provider's practice in relation to caring, we used the 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. Our SOFI findings concluded that staff regularly interacted with people in a positive way, seeking opportunities to engage with people beyond undertaking care tasks.

We looked at some bedrooms, and found that people's rooms were highly personalised. The rooms we looked at contained people's personal belongings which contributed to a homely and personalised feel in each room.

Staff described how they offered people choice, such as where and when to eat, what clothes they wanted to wear and the time they liked to go to bed and get up. People we saw were well groomed, in smart, clean clothes and sometimes wearing jewellery and other accessories. This indicated that staff had taken time with people when helping them to get ready for the day, ensuring they could reflect their personal preferences in the way they dressed.

When we observed staff practice in relation to choice, we noted that mostly staff promoted people making choices and decisions, although on occasion this lapsed. For example, during lunch we observed a staff member enter the dining room looking for condiments. They took the condiments from a table where two people were sitting without checking first whether the people had finished using them. Another staff member was observed to pre-empt people's decisions about what they wished to eat, without checking with them.

The staff we observed upheld people's dignity, speaking discreetly with people about any care needs, knocking on doors and addressing people using their preferred names. However, we noted a few isolated examples where staff appeared to approach people in a task oriented manner, for example discussing which person was to be "done next" which we interpreted to mean which person was to be given support next. Nevertheless these incidents were in the minority and did not reflect the majority of interactions we saw.

We checked five people's care plans and saw that their needs and preferences were clearly set out, so staff had clear guidance about how to support people and provide care which met their needs. Care plans were personalised, and each one reflected the person concerned in detail. The staff we spoke with demonstrated a good knowledge of the people living at the home, their care needs and their wishes. However, one staff member, who had been carrying out the role of care assistant for a few weeks at the time of the inspection, did not have an account to enable them to access people's electronic care plans, and could therefore not read details about how people should be supported.

We asked the home's assistant manager whether there were any dignity or dementia champions within the staff team. A dignity champion is a staff member who signs up to act as a good role model to educate and inform all those working around them, in order to promote dignity in people's care. Likewise, a dementia champion is a staff member whose role is to promote knowledge around the specific needs of people with dementia and promote good practice. The assistant manager told us that at the time of the inspection the home did not have any staff with such responsibilities.

The provider had developed a daily bulletin which was circulated amongst people using the service. This promoted involvement as it gave information about what was happening within the home and any planned developments. This appeared to be well received.

Good

Is the service responsive?

Our findings

People we spoke with told us they were happy with how the provider assisted them with their health needs, and praised the staff. None could describe anything they would change or improve.

We looked at the arrangements for providing activities in the home. The provider employed two activities co-ordinators, who promoted a range of activities both inside and outside of the home. On the day of the inspection a trip to York Railway Museum was taking place, and there had also been a recent trip to the coast. Staff described that plans were under way to organise a shorter trip to local attractions which would be more suitable to people whose health needs meant that they couldn't undertake a longer trip. Within the home there were regular planned events such as needlecraft classes, film nights and visits from the Salvation Army

Care plans reflected that people's preferences and choices were considered in the way their care was delivered, and our observations during the inspection showed that people's preferences were adhered to.

We found that people's care and treatment was regularly reviewed to ensure it was up to date. Each care plan had evaluation records, showing that staff had reviewed whether the care being provided met people's needs. We also saw evidence of care plans being changed to improve the way people were cared for when their needs changed.

Where people required the input of an external healthcare professional, this was promptly sought and their guidance was acted upon. Care plans we checked evidenced that the way people were cared for was changed to ensure that external healthcare professionals' directions were incorporated.

We checked records of complaints within the home, and saw that when people had made a complaint this was addressed promptly by the registered manager, and in accordance with the provider's own policy. People we spoke with said they would be confident to make a complaint if they wanted to, but stressed that they had nothing to complain about.

The arrangements for making a complaint were described in the service user guide, which was given to all people when they began using the service. The complaints process was on display in the communal area.

People using the service and their relatives were encouraged to give feedback about the home. This was via an annual survey and regular meetings. Minutes from meetings of relatives and people using the service showed that the provider had responded to feedback. For example, the variety of snacks on the home's snacks trolley had increased in response to requests from people using the service.

In addition to surveying people using the service and their relatives, the provider surveyed professional visitors. We looked at the responses submitted by professional visitors for the month preceding the inspection, and found they were all positive. One responded they were "impressed with [the] professionalism of staff" and another recorded: "Very pleased with help and support from staff when I visit."

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the service had a manager in post who was registered with the Care Quality Commission. In addition, the registered manager was supported by deputy managers and an assistant manager, who were all qualified nurses. The provider is part of the Crown Care group of homes, meaning that there was also a structure of regional and operations managers who provided support and guidance to the home.

Staff told us they enjoyed working at the home. They told us that morale had improved and they felt they could communicate with the management team. We checked minutes of staff meetings and saw that staff were able to contribute their views and ideas in relation to the way the service was run. Staff told us they felt senior management communicated well with them.

Various audits had been used to make sure policies and procedures were being followed and essential checks were carried out. These audits looked at areas including health and safety, care plans, personnel records and staff training. We checked a sample of these, and found that they were very thorough and identified areas for improvement. Where areas for improvement were identified, an action plan was formulated and followed up at the next audit to ensure it had been addressed.

The operations manager had introduced a new audit tool at the time of the last inspection, which was a thorough, regular check of a number of key areas of the home's operations, including medication management, safeguarding of vulnerable adults, health and safety and personnel issues. At the time of the last inspection, as the tool had only just been introduced, we could not assess its effectiveness. At this inspection we saw that the tool was effective, and ensured that the home was operating safely and providing a quality service.

Systems were in place to make sure that the registered manager and staff learned from events such as accidents, complaints and incidents. There was a thorough analysis of accidents and incidents, which identified trends and patterns so that any areas of risk could be addressed. We checked records of incidents and accidents, and noted that relevant incidents had been notified to the Care Quality Commission and the local authority, as required.

Staff received regular supervision and appraisal. We checked the provider's supervision and appraisal schedule and saw that appraisals took place annually, with supervision taking place around every two months, although this had not yet been fully embedded. Managers at the home told us this was an area they were working on improving and was a main focus for them at the time of the inspection. Staff we spoke with confirmed that they received supervision and told us they found this useful.