H G M MEXBOROUGH LLP

# Highgrove Care Home

## Inspection report

West Road
Mexborough
South Yorkshire
S64 9NL

Tel: 01709578889

Date of inspection visit:
09 February 2016

Date of publication:
04 March 2016

## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|

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

# Summary of findings

## Overall summary

The inspection was unannounced, and took place on 9 February 2016. The home was last rated in February 2015 where it was given an over all rating of inadequate. Further, non-ratings, inspections took place in June and July 2015. Breaches of regulations were identified during these inspections, and we are currently taking action against the provider in relation to this. We will report on this action at a later date.

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 37 people living at the home. The home is divided into four discrete units, although the provider has stopped using one of the units and therefore only three 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 did not have a registered manager. However, the home's manager had applied to the Care Quality Commission to become registered and her registration interview took place during the inspection. 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.

We found that staff had a caring and patient approach when supporting and caring for people. They took steps to uphold people's privacy and dignity, and treated people with respect and kindness. Staff had a good knowledge of people's needs, and there were plentiful activities within the home.

Safeguarding arrangements in the home were effective; staff were knowledgeable and trained in this area, and appropriate procedures had been followed when abuse or suspected abuse had occurred.

Care records were not always fit for purpose. Some lacked detail or were out of date or contradictory. When care records were reviewed, the reviews did not always result in relevant changes being made to people's care plans or risk assessments. We identified instances where care was not being provided in accordance with people's assessed needs.

People's nutrition and hydration needs were not always met. This was due to a combination of poor or absent recording, inaccurate recording, and care plans and risk assessments not being followed.

The arrangements in place for obtaining and acting in accordance with people's consent, and decision making when people did not have the capacity to consent, did not meet legal requirements. Although staff were trained in this area, we identified occurrences where best interest decisions had not been

appropriately made.

Medicines were well managed, and where there had been recent, untoward incidents in relation to medication, the provider had taken appropriate steps to address this. However, the arrangements for auditing medicines were not robust.

The systems and processes in place to ensure compliance with relevant regulations were not effective. Although the provider told us that new systems were in the process of being introduced, the Commission had informed the provider 18 months earlier that their existing systems of quality monitoring were inadequate, and the provider had failed to address this in a robust or timely manner.

## 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. Appropriate safeguarding arrangements were in place, and staff were trained and knowledgable in relation to safeguarding.

Risk assessments were not always accurate or fit for purpose, and staff did not always take appropriate steps when adhering to risk assessments and protect people from harm.

Medicines were safely managed, although the arrangements for oversight and auditing the medication system needed improvement.

### Is the service effective?

**Requires Improvement**

The service was not effective. The arrangements in place for obtaining and acting in accordance with people's consent did not meet legal requirements.

There was little evidence of best interest arrangements being pursued where people lacked the capacity to consent, meaning that decisions were made for people without appropriate legal processes being followed.

Where people were at risk of malnutrition or dehydration, the provider had failed to take adequate steps to minimise these risks

### Is the service caring?

**Good**

The service was caring. Staff showed respect and kindness in their interactions with people. People told us they felt the staff were caring and enjoyed their company.

Staff upheld people's dignity and privacy when providing support, and were knowledgable about people's needs and preferences.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive. Care was not always tailored to people's changing needs, and reviews of people's care

were not always meaningful or effective.

There was a comprehensive plan of activities at the home, including in-house events and involvement in the local community.

## Is the service well-led?

**Inadequate**

The service was not well led. The arrangements in place for monitoring the quality of the service were not robust enough to identify or address shortfalls in service quality.

We saw comments from both relatives and staff stating that they did not feel the provider communicated well, but we saw no action plan or steps to address and improve this.

When we inspected the home in August 2014 and February 2015, we set out in the subsequent reports that the arrangements for monitoring the quality of the service were poor. The provider had not taken steps to address this until November 2015, and the systems it had introduced had not been embedded so it was not clear what their future effectiveness would be.

# 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 checked 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.

The inspection was unannounced, which meant that the home's management, staff and people using the service did not know the inspection was going to take place. The inspection visit was carried out on 9 February 2016. The inspection was carried out by two adult social care inspectors, an inspection manager and a registration assessor. During the inspection, the registration assessor carried out an interview of the manager in relation to her application to become the registered manager of the location.

During the inspection we spoke with staff, the home's manager, and senior representatives of the company. We spoke with people who were using the service to gain their views and experiences of receiving care at the home. We checked people's personal records and records relating to the management of the home. We looked at team meeting minutes, training records, medication records and records of quality and monitoring audits.

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.

Prior to the inspection, we reviewed records we hold about the provider and the location, including notifications that the provider had submitted to us, as required by law, to tell us about certain incidents within the home. We also spoke with the local authority to obtain their views about the home's performance.

Requires Improvement

# Is the service safe?

## Our findings

We spoke with two people using the service about whether they felt the home was safe. They both said that they felt it was. One person said to us: "I'm very safe, I don't have to worry about anything here." Another told us: "It's very safe because they [the staff] know what they are doing."

During the inspection we carried out observations of people receiving care to assess whether there were staff in sufficient numbers to meet people's needs. We observed that staff attended to people quickly, and whenever people requested attention or support. The home's manager told us that staffing numbers were calculated by assessing people's dependency, and that the numbers could therefore fluctuate according to need.

We checked whether staff had received training in moving and handling, to ensure whether they knew how to support people to mobilise safely. The provider's training matrix showed that all staff had received this training. Staff we spoke with confirmed they had received training in moving and handling. We observed staff undertaking moving and handling tasks, assisting people to move around the building or transfer from chairs to wheelchairs. This was done safely and staff had a good understanding of the techniques required to keep people safe. An external moving and handling assessor had recently visited the home and we saw their feedback, which was positive with some recommendations for further areas of improvement.

Staff we spoke with told us that they had received training in the safeguarding of vulnerable adults, and the provider's training matrix confirmed this. Staff could describe the processes they should follow if they suspected abuse, and when we checked CQC's records we could see that relevant incidents had been appropriately reported to the Commission.

We checked nine people's care plans, to look at whether there were assessments in place in relation to any risks they may be vulnerable to, or any that they may present. All the care plans we checked contained risk assessments relevant to the person. However, they were not always fit for purpose, or being adhered to. For example, one person's care plan indicated that they were at risk of malnutrition. The related risk assessment, which set out how they should be protected from this risk, stated that their weight should be monitored weekly, but records indicated that this was not being done. Another person's care plan had no information about how staff should protect them from the risk of harm their challenging behaviour could present. A third person's care plan showed that they had bed rails in place when they were in bed. Bed rails can present a risk of entrapment if not carefully managed, and their use should be regularly reviewed to ensure this form of restraint is still appropriate. The risk assessment in relation to the safety and suitability of bed rails had not been reviewed for almost a year.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Recruitment procedures at the home had been designed to ensure that people were kept safe. All staff had to undergo a Disclosure and Barring (DBS) check before commencing work. The DBS check helps employers

make safer recruitment decisions in preventing unsuitable people from working with children or vulnerable adults. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable adults. In addition to a DBS check, all staff provided a checkable work history and two referees. We checked a sample of four staff members' personnel files, and found that all appropriate pre-employment checks had been undertaken.

We observed part of a medicines round taking place in the downstairs lounge of the home. We saw that Medication Administration Records (MAR) had a photograph of each person to help ensure the correct identification of the person receiving their prescribed medicine. We saw that the staff member administered medicines in a safe way. They checked whether people were experiencing any pain to establish if they required any pain relief medicines. We saw they spoke with people who used the service in a kindly and patient manner and waited for them to take their medicines before moving to the next person. The medicines administration procedure was available at the front of the file containing the MAR sheets for staff to refer to.

We looked at the MAR charts for 11 people receiving their medicines. The medicines on the MAR charts were correct with the medicines listed on the prescriptions. Where people who used the service were prescribed medicines as required, for example pain relief medicines, we saw there were protocols in place giving staff guidance of how and when to administer these medicines. We saw stock levels had been checked and were found to be correct. We saw there was one signature gap for one dose of medicine on one MAR but on the records we checked all were signed to confirm they had been administered or a code used to identify why the medicines had not been taken.

We saw the medicines fridge temperatures were recorded daily although there was an occasional gap in recording. The temperatures were consistently within the acceptable temperature range and there was a procedure for staff to follow should the temperature fall outside of this range.

We checked the records of two incidents that had been reported to the local safeguarding team as medicines errors. We confirmed these had also been reported to CQC. We saw there was a detailed account of the errors and what action was taken to address these and prevent reoccurrence. For one error the actions specified was for the staff member to undergo a supervision session, further medicines training and a medicines competency assessment. We saw that a supervision session had taken place and a medicines competency assessment carried out two days after the error had occurred. Further training had been scheduled to take place in the week of the inspection.

There was a list of staff who administered medicines to identify their initials on the MAR charts. The list included 30 names including agency staff however when we checked this against the number of staff who had received medicines training we found this list was out of date. We found 10 staff included on the list had left the service, one who had left in 2014 or staff who were no longer authorised to administer medicines. We confirmed which staff were still authorised to administer medication, and found that they had all received training in the preceding 12 months.

Requires Improvement

# Is the service effective?

## Our findings

We asked four people using the service about the food available in the home. They told us that the food was good, and that it was plentiful. One person said: "They do the meals I like, all my favourites." Another said: "I do like the food, it's always good."

We carried out an observation of a mealtime in the home. Staff supported people to choose where to sit, and who they sat with. Staff appeared to know people's preferences well, but took time to ensure they offered a choice of both food and drinks. Where people required assistance with their food, staff did this discreetly and respectfully, and ensured people had time to enjoy their meal.

We spoke with kitchen staff and found that they had a good knowledge of people's dietary needs and preferences. They told us that food was sourced from local suppliers, and meals were fortified to promote good health. They had records showing which of the 14 allergens any dishes included, in accordance with recent requirements implemented by the Food Standards Agency.

We checked nine people's care records to look at information about their dietary needs and food preferences. We found that each person had an assessment of their needs in relation to nutrition and hydration, however, their needs were not always met. For example, one person's records had a target amount of liquid that they should drink each day in order to maintain good health. This target had not been met on any day in the week preceding the inspection. Staff had recorded that the person had taken a full drink that morning, but when we checked the person's cup was still half full and they told us their drink was cold so they no longer wanted it, therefore the records in relation to their hydration were not correct. The provider's operations director told us that this issue would be addressed by the introduction of a new pro – forma, however, the records we had looked at were already on the new pro – forma, so the measures intended to improve inaccurate recording had not been effective.

The manager told us that staff had received Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training, but said that some staff still required training, which was booked. 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 (DoLS)

CQC's own records showed that the provider had notified the Commission, as required, when an application to deprive someone of their liberty was made. People's care plans showed that these had been made when required, and that their status was monitored.

We 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. People's care plans did not reflect appropriate decision making in accordance with the MCA. For example, one person's file showed that they did not have the capacity to consent to their care. There was a record in their file which stated that a best interest decision had been reached in relation to their "care and treatment" however, it did not detail what aspects of care and treatment it was in their best interests to receive. Best interest decisions should be specific rather than generic, meaning that care and treatment was not being provided to this person in accordance with the MCA.
Another person's records stated that they were unable to make informed decisions. There were best interest decision making records relating to some aspects of their care, but their records indicated that they had recently moved rooms within their home, to which they had given their consent and therefore no best interest decision making had taken place. As records showed that this person did not have the mental capacity to consent to any aspect of their care and treatment, it was unclear how the provider had been assured that they had made an informed decision to move rooms. A third person's file indicated that they had the mental capacity to consent to their care, but their records included information stating that a best interest decision had been reached in relation to them receiving care and treatment. This did not adhere to the requirements of the MCA as other people had made decisions on the person's behalf despite them having the capacity to do so.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff we spoke with told us that training they had received had been useful and helped them do their jobs. One staff member told us that they were enjoying doing distance learning in nutrition, and another told us they could request additional training if required and that they had requested and completed first aid training.

Staff told us they felt they received good information and communications from the home's management team, but some commented that they did not feel the provider communicated effectively with them.

Good

# Is the service caring?

## Our findings

We asked four people using the service about their experience of the care and support they received. Their responses were all positive. One person said the staff were "all lovely." Another said: "I couldn't pick a favourite, they are all good." One person we spoke with told us about one staff member in particular who they said was "perfect."

We carried out observations of staff interactions with people using the service throughout the inspection. Staff were consistently kind and patient with people, and provided support which was tailored to each person's needs. Staff we spoke with understood people's needs well, and spoke with warmth about the caring aspect of their roles. One staff member described how they had supported one person to go out and choose wallpaper for their bedroom, and told us "I love my job here, it's a calling rather than a job."

Where staff needed to discuss people's care needs, in order, for example, to plan their tasks, they did so in a discreet manner, upholding people's confidentiality and dignity. Staff we observed routinely left the room if they needed to discuss someone's care, so that the discussion couldn't be overheard, although we did note one incident where two staff members discussed sensitive details about a person's family in an office with an open door, which could be heard clearly in the communal area of the home.

We spoke with staff about how they upheld and respected people's dignity and individuality. One member of staff told us: "I think about it like they were my mother – how would I want her treated?" Another told us they thought it was important for the home to feel homely, and we saw that the provider had taken steps to make the environment welcoming and pleasant. Staff also appeared to know visiting relatives very well, and we saw that relatives were invited to join people at mealtimes.

The nine care plans we looked at had been written in a person-centred way. Each one contained information in relation to the person's needs, likes, dislikes and preferences and identified people that were important to them. It was therefore evident that people were looked after as individuals and their specific and diverse needs were respected. However, each care plan had a section for people's personal histories, intended to enable staff to gain a holistic view of the person, and this had not always been completed.

We checked a sample of people's bedrooms and saw they were personalised with items they had brought from home. We asked one person about this and they said: "These are all my things from home, there was no problem bringing them in."

Requires Improvement

# Is the service responsive?

## Our findings

There were a large number of activities available for people to take part in, both inside and outside the home. Trips out were planned regularly, and events were planned in the home; a Valentine's lunch was planned for the week following the inspection. During the inspection a singer came to the home to entertain people, and a game of bingo took place which was well managed to ensure people were involved and participating. People told us they enjoyed the activities available to them. The home employed a dedicated activities co-ordinator, who was observed to be knowledgeable about people's needs and preferences.

We checked care records belonging to nine people who were using the service at the time of the inspection. We found that care records contained details of people's assessed needs and set out in detail how staff should support people. However, when people's care was reviewed, appropriate changes were not always made to their care plans. For example, one person's care records showed that they were experiencing significant weight loss and external professional input was being sought, but their care plan had not been updated to reflect this. Another person's records showed that staff had judged that they needed to be weighed weekly, but their care plan did not state this.

The provider's policy was that people's care should be reviewed every month, and we saw that on the whole this frequency was adhered to, although we saw some exceptions where this had not taken place.

We looked at daily notes and recording charts and found that people were not always receiving care in the way that they had been assessed as requiring. In two people's notes we found that they had targets recorded for the amount of fluid they required each day, however, this target was not been met. There was no evidence of any action or review undertaken to consider how to better support each person to ensure their assessed needs were met. One person's daily notes showed that staff had been concerned about a skin reaction they had developed, but there was no body map to reflect this, meaning that there were no records relating to the location or severity of the skin condition.

There was information about how to make complaints available in the communal area of the home, and people we spoke with told us they would feel confident in making a complaint should they feel the need to. We checked records of complaints and found that each one was responded to within an appropriate timescale.

Inadequate

# Is the service well-led?

## Our findings

The home's manager had applied to CQC to become the registered manager of the service, and was interviewed during the inspection in relation to this application. They were supported in their role by unit managers and administrative staff. The provider had recently recruited new senior personnel, including an operations director and a regional manager, who both attended during the inspection and had input into the home.

Weekly meetings took place for heads of department, and team meetings were also taking place. We checked the minutes from recent meetings and found that they were used to discuss developments and improvements in the home, as well as people's needs and staffing and personnel issues.

The provider surveyed people using the service and the relatives for their views on the service. We looked at the most recent survey, which took place in May and June 2015. A summary sheet of comments had been developed, but this only contained the positive comments received. Three of the respondents had raised concerns about feeling the provider did not communicate well with them, and one had raised concerns about an area of perceived risk. The attached action plan did not address any of these areas.

We looked at the arrangements for supporting staff via supervision and appraisal. We were told that the provider's policy for staff supervision was that it should take place six times per year. Each line manager was responsible for their own staff supervisions. The staff supervision spreadsheet showed 15 of the 55 staff included on the spreadsheet were not up to date. However this was incorrect as we were told there were currently 61 staff working at the home. This meant that the systems by which the home's management team monitored the effectiveness of supervision was not fit for purpose.

The home's computer system showed 65 staff were employed at the service, including three bank staff. Four staff were off work on a long term basis at the time of the inspection. 60 staff were identified on the training matrix, 55 staff on the staff supervision spreadsheet and 14 staff on the annual appraisal spreadsheet. The training matrix should have identified 65 and although it is acknowledged that it may not have included the four staff who were off work long term, there still should have been 61 staff included. These were inconsistent with the number of staff employed and could not provide an accurate overview for the provider to monitor training, supervision and appraisal

The home's manager provided us with quality audits which had been undertaken in relation to various aspects of the home's running; these included monitoring governance, medication, care plans, health and safety and the condition of the premises. In addition to this, a senior manager's audit had been commenced. There was one in progress during the inspection, and following the inspection the provider supplied us with one that had been completed two months earlier. It was the provider's intention to add a more comprehensive audit tool, but as this had been commenced the day before the inspection, we were unable to assess its effectiveness. When we inspected the home in August 2014 and February 2015, we identified concerns in relation to how the provider audited the service, and how they assured themselves of the quality of service people received. The new audit system we saw had only been introduced in November

2015, meaning that the provider had failed to act with sufficient responsiveness to the concerns identified 18 months earlier.

We carried out a check of care records, and found that they contained errors and omissions which had not been identified by means of any audit. For example, in some of the care plans we sampled, information about people's life history was missing. In one person's care plan there was conflicting information about their ability to consent to their care and treatment. In another person's care plan they were not being weighed at the frequency they had been assessed as requiring. None of the audits we checked had identified these shortfalls or resulted in them being addressed. When we were checking the care plans, which were in electronic format, we noted that the electronic system automatically alerted managers to areas that were out of date within each care plan. This had not been acted upon.

The provider had a system of "supplementary records." These were files for each person which contained details of night time checks, records of positional changes where required, and food and drink charts. In some of the supplementary records we checked, we found omissions and inaccurate information. Six people's supplementary records were insecurely located in a communal lounge area. These issues had not been identified by way of any effective audit system.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff we spoke with gave us positive feedback about the home's manager, and said that they found them to be approachable, however, a recent staff survey showed that some respondents did not feel that the provider communicated with them effectively. We were not provided with any action plan which set out how the provider intended to address this, so could not judge its effectiveness.