Rushcliffe Care Limited

Highfield Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Highfield Court is a residential care home providing personal care to 44 people who have learning disabilities, autism and/or mental health needs. The service can support up to 59 people.

The accommodation is divided in to 23 separate bungalows. Some people live in small groups of between two and six and some people live alone. Some people had their meals in their bungalow while others had their meals in a bistro located on site. There was an activities area and large gardens people accessed.

People's experience of using this service and what we found
People did not receive care which was personalised to their individual needs due to the model of care in place. We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.
Right support:
• The model of care in place did not offer people ordinary living opportunities.
Right care:
• People did not receive care which was personalised to their needs and actively promoted their independence.
Right culture:
• People's individual needs were not always considered, and people were not always encouraged to have aspirations for the future.

The governance systems in place had improved since the last inspection. However, they were still not identifying all areas of concern meaning the provider could not always keep people safe. The guidance seen in some of the care plans did not reflect best practice.

The provider did act when it was highlighted something had gone wrong. The registered manager was described as approachable. People and the staff team told us complaints were now addressed at the time.

Risks to people's safety were assessed but staff did not always complete records to confirm the mitigation strategies had been adopted. For example, ensuring people receive specific drinks throughout the day. People received their medicine as prescribed, but the medicine audits had not identified all the issues the management team needed to address.

Infection prevention control policies were in place to manage the impact of COVID-19, but the provider was yet to complete individual risk assessments and ensure cleaning records were completed.

People were supported by enough staff members although they did not know until the day who would be working with them. People's needs were assessed, and care plans were developed and reviewed on a regular basis. People did not have access to health action plans to support them in managing their health needs.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The provider engaged with people and the staff team to gather their views on the service and future activities. They also worked in partnership with external agencies to support people and the development of the service.

The environment was undergoing refurbishment. Rooms were being decorated and house hold appliances were being replaced.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was requires improvement (published 08 October 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found there were still breaches of the regulations in some areas but in other areas there had been enough improvement to remove previous breaches.

This service has been inspected four times since 2017. On one of those inspections the service was rated inadequate and on the other three inspections the service was rated as requires improvement.

Why we inspected

We carried out an unannounced focussed inspection of this service on 26 August 2020 and an unannounced comprehensive inspection of this service on 07 October 2019. Breaches of legal requirements were found at both these inspections. We imposed conditions on the provider as a result of these breaches and undertook this focused inspection to check they were meeting the conditions and to confirm they now met legal requirements. The provider had also submitted an application to CQC to have the conditions removed. This report only covers our findings in relation to the Key Questions Safe, Effective, Responsive and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained requires improvement.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took

account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to how people were protected from abuse and the level of person-centred care people received. We also found a breach with the overall governance of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service responsive?

Requires Improvement

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Highfield Court

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 Care Act 2014.

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 two inspectors and an assistant inspector.

Service and service type
Highfield Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. We spoke with the management team before entering the premises to establish their COVID-19 status and confirm the required Personal and Protective Equipment (PPE) we needed to wear.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We reviewed information the provider had sent us as part of their conditions. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to

give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with 10 people who used the service and one relative about their experience of the care provided. We spoke with13 members of staff including the provider, registered manager, deputy manager, team leaders, and care workers.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at four additional care plans, training data and quality assurance records. We also held discussions with the local authority and the provider.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

Systems and processes to safeguard people from the risk of abuse
• At this inspection we found one person's care plan contained guidance for staff which had the potential to cause the person harm. We found the guidance permitted staff to remove or deny the person certain items, as a consequence of not doing certain tasks. This is not in line with best practice. We also saw a recommendation for staff to redirect the persons attention when they complained about staff. This had the potential to prevent the person being listened to when they had concerns about their safety. We alerted the provider to our concerns and the care plan was altered.
• People lived in shared accommodation but who they shared with was not always considered in terms of the risk of harm. We identified people sharing accommodation with people whose behaviour had the potential to cause harm to another. For example some people were exposed to passive smoking and others name calling. When we questioned the management team about this, we were told people had lived together a long time and it had never presented as an issue. We recommended the provider completed regular reviews to ensure people knew they always had a choice of who to live with.

While we found no evidence of people being harmed, we found the necessary safeguards to protect people we not always in place. This is a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• People were supported by staff who were trained in recognising and reporting abuse. Staff also had access to policies and procedure's from both the provider and local authority to ensure they were aware of the various processes available to them.

At our last inspection the provider had failed to ensure the risks to people were being assessed and managed appropriately. These risks were in relation to medicines, infection control and support for people with additional health needs. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At this inspection we found enough improvement had been made to remove the breach. However, further improvements were still needed.

Assessing risk, safety monitoring and management
• At the last inspection we found concerns regarding the monitoring of people's fluid intake and the action staff needed to take when people faced a health emergency. At this inspection we found there had been improvements but there were still instances where fluid monitoring was an issue.

• One person told us they were supposed to have a specific drink several times a day to support their health needs, but this did not always happen. We checked the person's daily records and our findings supported what the person told us. We spoke with the staff member on duty. They told us they didn't usually work in the particular bungalow so were unsure what was required, but would support the person to get the required drink. We spoke with the management team who reassured us the person was getting their drinks but acknowledged the records did not always support this. This meant the risks to people's safety could not always be mitigated as there was no accurate record of what care had been delivered. People were also being supported by staff who were not always up to date with their current needs.

Using medicines safely
• At the last inspection found people did not always receive their medicine in line with requirements. At this inspection we found there had been improvements and people were being given their medicine as prescribed. However, we still found improvements were needed around the storage of medicine.
• We found staff had been removing a medicine from its packaging and storing a daily supply in the person's bedroom without any labelling. We also found staff were not routinely recording room temperatures to ensure medicine was stored at the correct temperature. The provider took immediate action to remedy the situation and acknowledged their own medicine audits had not drawn their attention to these issues.
• People were now able to access homily remedies in line with national guidance and more people were asking if they could self-administer some of their own medicine. This was a positive step as the practice had previously not been possible.

Preventing and controlling infection
• We were somewhat assured that the provider was meeting shielding and social distancing rules. This was because the office space both inside and out was frequently crowded with staff and people milling about.
• We were somewhat assured that the provider was using PPE effectively and safely. This was because individual risk assessments were yet to be carried out to ensure the correct level of PPE was being worn for each person.
• We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning records were not routinely completed by staff and therefore it was not possible to be assured on how often cleaning tasks were being completed.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
• We have also signposted the provider to resources to develop their approach.

Staffing and recruitment
• At the last inspection, the registered manager had introduced 'zoning' to ensure there was better deployment of staff and limit the number of people each staff member worked with. However, we were not clear at this inspection whether it had been successful as we received mixed reviews regarding the staffing. Everyone we spoke with told us the staffing levels had increased, but one person told us, "I feel safe here, but we have different staff in the house, I would prefer the same ones." A staff member told us, "I work in any of the units, we used to have set units, I think this was better."
• When we looked at the rota we could not see who staff were working with and whether people experienced a consistent team. We discovered staff were allocated to the people they would be working with on the day

of their shift. This meant people and staff were not always able to plan ahead as they did not always know when they would next be together.
• Staff were recruited following the application of robust recruitment procedures. The provider checked their character, background and qualifications to ensure they were suitable to work with adults in a care setting.

Learning lessons when things go wrong
• The provider was able to evidence lessons had been learnt due to the improvements made between the present and previous inspections. However, we found the provider was still not always identifying for themselves when something went wrong.
• We reviewed the accident and incident file and found the provider had implemented a detailed investigation process which included lessons learnt and how information should be disseminated to the staff team.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At last comprehensive inspection the provider had failed to ensure the principles of the Mental Capacity Act (2005) were being met. This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. At this inspection we found enough improvement had been made to remove the breach although we noted further work was still required.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• At the last inspection we found staff had limited understanding of the principles under pinning the MCA and there was a lack of documented evidence to support decisions being made in people's best interests. At this inspection we found there had been significant improvements. Staff demonstrated a greater understanding and MCA assessments were included in people's care plan.
• We did question the language used within some of the assessments we saw, as a number of care plans contained generic statements suggesting people could not do something because they had a learning disability. The same statement was applied to people with a range of abilities. This meant we could not be sure why a person may not be able to complete a certain task, as their individual circumstances were not made clear.
• Applications to deprive people of their liberty were submitted and assessed by the local authority. We confirmed any conditions were being met. We questioned whether all restrictions were being included in applications as we noted one person used bedrails and these were not mentioned in the documentation. We were told this person had a meeting the following day to review their DoLs paperwork. Following this meeting the provider gave reassurance the use of bed rails was now included.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

• Peoples needs were assessed, and the provider had developed a more detailed pre-admission assessments for anyone new coming into the service.
• People's care plans had now been fully uploaded to an electronic care planning system. The care plans were more detailed that previously seen and they were reviewed on a regular basis.
• People's voice was echoed in the care plans and reference was made to when family views had been sourced.
• We found evidence of best practice being adopted in certain areas. For example, oral health care. However, there was further work required to ensure all aspects of people's care was in line with nationally recognised guidance.

Staff support: induction, training, skills and experience
• People were supported by staff who had received training in subject's mandatory to adult social care. Staff told us they completed mental health training, but the provider gave us evidence that only half the team received training on the subject. This concerned us due to the complexity of some people's needs and the need for staff to support people to manage their symptoms. We also struggled to find evidence of staff receiving food hygiene training and was told this was delivered as part of the course on nutrition.
• Staff told us they thought the training was good, covered what they needed, and the provider would arrange specific courses if needed. The provider advised us following this inspection, they would be focussing on the mental capacity act and the use of language in people's care plans.
• Staff confirmed they received supervision and appraisal which meant they were given the opportunity to discuss any concerns and review their practice alongside any additional training needed.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to eat and drink throughout the day. People could access food and drinks in their own bungalows or visit the bistro which was open during the day.
• People did not always have a say in where they could eat their meals or make personal choices about what to eat, due to the model of care in place. Some people still accessed the bistro for all their meals which meant choices were available but somewhat limited to a few options per day.
• People who needed additional support due to swallowing difficulties were supported. We could see referrals had been made to gather professional input and seek recommendations on the food consistency required.

Staff working with other agencies to provide consistent, effective, timely care
• The provider was working with outside agencies to support the service to develop and meet people's needs. The provider shared a range of documents with us as part of the inspection process to highlight some of that work.
• Since the last inspection the provider had engaged the various local authorities who commission services, to review people placed at Highfield. They had worked together to identify people who may have been inappropriately placed in the past and supported them to move on to an alternative service provision.

Adapting service, design, decoration to meet people's needs
• People lived in small bungalows on site. Most of the bungalows had seen some recent refurbishment and plans were in place to complete the refurbishment of other areas. Some people required new appliances in their home due to damage and a date for replacement had been issued. At the last inspection we raised a concern about some of the mattresses and were told by one person that theirs had been replaced since our last visit.
• On the day of inspection, a new phone system was being installed to ensure people in the bungalows had access to a land line telephone.
• People were able to contribute towards discussions about the refurbishment of their own bungalow and

the wider environment. People's bedrooms were personalised to their needs and people were involved in the refurbishment of the bistro area.

Supporting people to live healthier lives, access healthcare services and support
• People were supported to attend hospital appointments and manage any presenting health conditions. However, we did not see evidence of the provider utilising Health Action Plans or Hospital Passports to support people manage their health needs in line with best practice. Health Action Plans and Hospital passports are recommended in NICE guidance to help improve the health outcomes for people with learning disabilities, especially as they get older.
• The provider told us they were currently using grab sheets and sharing the persons care plan with medical professionals instead. We discussed the risks of not sharing the right information and of over sharing information, as medical professionals may not need to know all the information held in someone's care plan. We recommend the provider reviewed the best practice guidance to ensure people were given the best opportunity to manage their health effectively.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

At last comprehensive inspection people were not receiving care that was wholly person centred. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. At this inspection we found there had been some improvement but not enough to remove the breach.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• At the last inspection people were not receiving care which was person centred and flexible to their individual needs. People had previously told us they were limited in the opportunities available to them on site and within the local community. At this inspection, despite the impact of the COVID-19 pandemic, people told us the activities on site had improved. However, there was still a lack of ordinarily living opportunities available. For example, some people had no opportunity to learn how to cook, complete domestic chores or do their own laundry as these tasks were allocated to ancillary staff.

• People were not receiving care, which was in line with Right Support, Right Care, Right Culture. The model of care in place did not allow people to develop or maintain their independent living skills.

• In some people's bungalows the allocation of staffing was limited to a few hours a day, meaning people did not always have enough time to spend with staff. We saw little evidence of people being encouraged to express and work toward their goals for their future.

• People's views were recorded in the updated care plans and reviewed with key workers on a regular basis. This was an improvement since the last inspection.

• People were supported to maintain relationships which were important to them. One person told us, "I have a relationship with [name]. We had to keep socially distanced due to Covid, but staff supported us to still see each other." People had been supported to maintain contact with family members and we saw some socially distance visits taking place.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's needs under the AIS were assessed and the outcome of the assessments were recorded in people's care plan.

• People had increased access to communication tools such as picture exchange cards and, posters were

being displayed around the site to keep people updated any future events. This ensured people were able to access information more effectively.

Improving care quality in response to complaints or concerns
• A complaints process was in place and people told us they knew how to complain. People told us they would go to the office and ask for a manager to support them. Most staff told us the complaints management process was much better. One staff member said, "Things definitely get sorted quicker these days."
• We reviewed complaints which had been received prior to the inspection and found they had been investigated and where necessary a resolution meeting was held. We reviewed one complaint which the provider had attempted to resolve via email. However, this proved to be ineffective and a face to face meeting was booked with the complainant to ensure a positive outcome was found.

End of life care and support
• At the time of inspection there was no-one experiencing end of life care. Staff told us they had received training and some people had funeral plans in place.
• The deputy manager told us they would be revisiting end of life care and support in the future as they acknowledged people were aging.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

At last inspection we found the governance systems were not always effective at identifying improvements needed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. At this inspection we found there had been some improvement but not enough to remove the breach.

This is fifth time the service has been in breach for good governance

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• The provider's governance systems were not always effective at ensuring the provider was meeting regulatory requirements. Since the last inspection improvements to the audit process had been made. However, certain risks to people safety and wellbeing were still not being highlighted. For example, the provider had not identified the unsafe removal of medicine from its packaging despite monthly medicine audits being carried out. The provider had not identified the inappropriate guidance being used in people's care plans which had the potential to cause harm. Neither had they found a way of ensuring staff completed records as required.

• People could not be confident staff were always aware of and followed best practice for adults with learning disabilities and autism. People did not have health actions plans or clear goals and aspirations for the future. Guidance recorded in people's care plans around behaviour support was not always in line with best practice and we did not find evidence of staff questioning the advice. This meant staff supporting the person may not be aware of the standard of care they should be achieving.

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

• People did not live in a service which actively promoted positive outcomes for them. The service was not meeting the principles of Right Support, Right care, Right Culture which reflects the key elements people with a learning disability should get from their service. However, people did tell us they were happy at the service. One person said, "The atmosphere has changed, staff are more involved and are doing more with us to keep us happy, it is great."

• Staff were generally positive about the service. One staff member commented "Since the registered manager came, changes have been made; it is like a village where everyone knows each other. Before I felt like nothing was ever done when we raised issues, but now things are dealt with." Another staff member told

us, "I think people are happier, staff have structured defined job roles, there is more accountability."

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 provider understood and acted upon their duty on candour although we could not be sure if the duty was applied on all occasions. This was because we saw one complaint where the provider's response showed some initial hesitancy in accepting there may have been shortfalls in the service provided.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People told us they were more involved in conversations about the service and appreciated sharing their views. One person told us, "We talked about the tuck shop and what we wanted, and it happened."
• People had access to monthly meetings where they could speak with the management team and ask any questions.
• People views and those of their families, were frequently reflected in people's care plans. In people's care plans it was clear when families wanted to be involved and what decisions were important to them.

Continuous learning and improving care
• The provider's quality assurance systems and process had increased since the last inspection. We found more in-depth investigations took place which reviewed all the evidence available and made changes when identified. This meant the provider was able to learn lessons and explain to staff where and why changes were needed.
• We recommend the provider reviews current best practice guidance to ensure the correct guidance was being adopted, especially around people's health needs and planning for the future.

Working in partnership with others
• The provider could demonstrate they were working in partnership with local agencies to improve the service provided. The provider had developed relationships with local commissioners and had begun discussions around the model of care needed at Highfield Court.

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 17 HSCA RA Regulations 2014 Good governance The providers governance systems were not always effective at identifying areas of concern.