Highfields Limited

Highfields Nursing Home

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 caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 20 June 2018. Highfields Nursing Home is a 'care home'. People in care homes receive accommodation and 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.

Highfields Nursing Home is registered to accommodate up to 42 older people in one building. Some of these people were living with dementia. At the time of the inspection, 23 people were using the service.

A registered manager was not present during the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager left the service in February 2018. Since March 2018, the home has been managed by an area manager. A new home manager started working at the service on 18 June 2018 and was in the process of applying to become registered with the CQC. We will monitor the progress of this application.

During our previous three inspections, we found the provider had consistently not met the minimum standard of 'Good' care for all people. At each of these inspections, we rated the service as 'Requires Improvement'. During this inspection, we checked to see whether sufficient improvements had been made to increase this rating to 'Good'. We found they had not and we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Therefore, due to the continued lack of sustained improvement at this service we have rated the question, 'Is the service well-led?' as 'Inadequate. The overall rating of 'Requires Improvement' remains.

You can see what action we told the provider to take at the back of the full version of the report.

People's medicines were not always appropriately managed. Risks to people's safety and managing behaviours that may challenge had been assessed, however care was not always provided in line with people's assessed needs. There were enough staff to support people safely; however, there was limited time for staff to engage in meaningful interaction with people. People felt the home was clean and tidy and staff had received training on reducing the risk of the spread of infection. Some parts of the home did require cleaning and updating to further reduce this risk. Accidents and incidents were regularly reviewed, assessed and investigated by the area manager.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice, although some assessments of people's capacity to make decisions required more detail. Staff received an ongoing training programme however staff performance was inconsistently monitored. People's physical, mental health and social needs were assessed and provided in line with current legislation and best practice guidelines.

However, there was an inconsistent approach to ensuring people's day-to-day health needs were always met. The majority of people liked the food however, records showed when people were at risk of losing weight they were not always weighed as often as stated as needed in their care plan. The ground floor environment needed adapting and improving to ensure people who had mental or physical disabilities were able to lead fulfilling lives.

Not all staff treated people with respect or dignity. We observed some poor interactions when staff were supporting people. We also observed some caring interactions; however, the time staff spent engaging with people, other than to complete to day-to-day tasks, was limited. Efforts had been made to include people in making decisions about their care. Where they were not able, information about how to access an independent advocate was available. People were encouraged to carry out some daily living tasks for themselves. People's records were handled in accordance with the Data Protection Act and there were no restrictions on people's friends or families visiting them.

People's care records were person centred and guidance was provided for staff on how each person would like to be cared for. However, care was not always provided in line with people's preferences. There were limited opportunities for people to engage in activities or to follow their own hobbies and interests. Only six staffing hours a week was assigned to support people with their interests. People told us this was not sufficient , with some telling us they were bored at the home. People's religious and cultural needs were met at the home. Not all information and records were presented in a way that would be accessible for all. People and relatives did not always feel complaints were handled appropriately, although records showed complaints had been responded to in line with the provider's complaints policy. The quality of the end of life care planning documentation was variable.

The service was not well led. The service has a history of non-compliance with the fundamental standards and/or failing to meet the minimum standards of 'Good' that services should never fall below. Although we found improvements in the quality of the care planning and risk assessments at this inspection, there were still a number of areas that needed improving. The area manager had implemented quality assurance systems that were designed to ensure that the quality of the care provided was monitored regularly. However, these were not yet managed effectively to help identify the issues we found during this inspection.

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 consistently safe.

People's medicines were not always appropriately managed. Care was not always provided in line with assessed risks. There were enough staff to support people safely; however, there was limited time for staff to engage in meaningful interaction with people. The home was clean and tidy although some areas of the home did need further maintenance. Accidents and incidents were regularly reviewed, assessed and investigated by the registered manager. People told us they felt safe at the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported to make decisions about their care, but more needed to be done to ensure the principles of the Mental Capacity Act (2005) were always followed. Staff received an on-going training programme; however, staff performance was inconsistently monitored. There was an inconsistent approach to ensuring people's day-to-day health needs were always met. People liked the food however; people were not always weighed regularly when needed. The ground floor environment needed adapting and improving to ensure people who had mental or physical disabilities were able to lead fulfilling lives.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Not all staff treated people with respect or dignity. We did see some positive interactions however; many of these were task-led. Efforts had been made to include people in making decisions about their care. People had access to an independent advocate if they needed one. People's independence was encouraged. People's records were handled in accordance with the Data Protection Act. There were no restrictions on people's friends or families visiting them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care records were person centred, however, care was not always provided in line with people's preferences or the guidance recorded within their care plans. There were limited opportunities for people to engage in activities or to follow their own hobbies and interests. People's religious and cultural needs were met at the home. Not all information and records were presented in a way that would be accessible for all. People and relatives did not always feel complaints were handled appropriately, although records showed complaints had been responded to in line with the provider's complaints policy. The quality of the end of life care planning documentation was variable.

Is the service well-led?

Inadequate

The service was not well-led.

The service has repeatedly failed to meet the minimum standard of 'Good' which services should never fall below. Some improvements had been made to care planning and assessing risk; however, there were still a number of areas that needed improving. The area manager had implemented quality assurance systems. However, these were not yet managed effectively to help identify the issues we found during this inspection.

Highfields Nursing 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.

This comprehensive inspection took place on 20 June 2018 and was unannounced.

Before the inspection, we reviewed information we held about the service, which included notifications they had sent us. A notification is information about important events, which the provider is required to send us by law. We also contacted Local Authority commissioners of adult social care services and Healthwatch and asked them for their views of the service provided. This informed our inspection planning.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

The inspection team consisted of an inspector, a nurse specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection, we spoke with six people who used the service and five relatives. We also spoke with: three members of the care staff, an agency nurse, clinical lead, kitchen assistant, assistant manager, area manager and the new home manager.

We looked at the records relating to 10 people who used the service as well as three staff recruitment records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints. The deputy manager sent us their training matrix and some specific policies and procedures after the inspection, as requested.

Requires Improvement

Is the service safe?

Our findings

The risks to people's health and safety had been assessed and guidance was in place to support staff with reducing these risks. However, we noted that staff did not always support people in line with guidance recorded on the risks assessments or their care plans. For example, we noted one person living with dementia had been assessed as having difficulties with sitting in their chair and repeatedly slipped down. Their care plan also identified that they had swallowing difficulties and required thickened fluids and a thick, pureed diet. Advice from the speech and language therapist in December 2017 stated they should be sat as upright as possible for all food and fluid intake and be upright for at least 30 minutes after eating and drinking. However, we observed staff assisting this person to eat when they were almost horizontal. There were also two care plans in place for eating and drinking safely, with one stating the person was to have a pureed diet however, there was no reference to this on the second care plan. This meant staff had not followed professional guidance to support this person and this placed their safety at risk.

We also noted staff did not always use appropriate moving and handling techniques to reposition this person and did not follow the recommended guidance as recorded within the person's care plan. This could have placed the person's safety at risk.

We recommend the provider reviews all risk assessments and care plans to ensure that people receive care in line with their assessed needs.

Other risk assessments were completed and reviewed effectively. This included nutritional risk assessments, pressure ulcers, falls and choking risk. Actions to reduce the risks were identified in people's care plans. When bed rails were in place and pressure relieving mattresses were used, staff had signed to say they had checked them daily. We found people's pressure relieving mattresses were set at the required level, which helped reduce the risk of people developing pressure sores. The home was safe and secure, with access to areas of the home that could cause people harm, such as the laundry, always locked. Access to the home could only be gained through a locked front door. Personal emergency evacuation plans were in place and reviewed regularly to help guide staff and emergency services on how to safely evacuate each person from the home quickly and safely. These measures helped to keep people safe.

Many of the people, relatives and staff we spoke with raised concerns about the number of staff available to support them or their family member. One person said, "I'm safe here, although they're run off their feet (staff)." Another person said, "I sometimes have to wait (for staff to arrive), I've got to take my turn." A third person said, "They haven't got time for people going out." A relative said, "[My relative] is safe here, however there's not really enough staff, they all seem very busy, but they are very helpful."

The area manager told us assessments of people's needs were carried out to ensure that the appropriate number of staff were in place to support people safely. From our observations, we found that overall; there were enough staff to support people. People received the support they needed with their meals and with moving around the home. However, the focus of the staff was predominantly task-led with little time left for engagement that was more meaningful. People were not left alone for long periods, but neither were they

engaged in any meaningful interaction from the staff that were monitoring them. The area manager told us they were aware of this issue and were working with staff to move away from a 'task-led' approach when supporting people.

Robust recruitment procedures were in place that ensured the risk of people receiving care and support from unsuitable staff was reduced. We reviewed three staff files and records. Criminal record checks had been carried out and proof of identity and references had been requested before staff commenced working with people.

People told us they felt safe living at the home. One person said, "If I was worried I'd tell them [staff], I'm the sort of person who'd tell them straight." Another person said, "I feel safe with staff and I don't really meet any residents, I don't go out of my room much."

People were supported by staff who understood how to protect them from avoidable harm. Staff were able to explain how they acted on any concerns they may have about people's safety. This included the process for reporting these concerns to the local authority safeguarding team. Records showed a safeguarding adults policy was in place, staff had received safeguarding adults training and any incidents that required reporting to external authorities had been done in a timely manner. This helped to protect people from potential abuse, neglect and harassment.

Strategies for managing behaviour that may challenge others were in place in people's care records where needed. This included monitoring of people's behaviour and where needed amending the care they received or the staff that supported them to reduce the impact of this behaviour. We did note one person's care records referred to the use of 'mild restraint of a person's arms' when personal care was provided. However, the staff we spoke with about this told us restraint was never used at the home. This person's care recorded needed updating to reduce the risk of them receiving care that could affect their rights.

People and relatives told us they were happy with the way they or their family members were supported with their medicines.

Medicines were stored safely in locked trollies and cupboards within a locked room. The refrigerator where some medicines were stored was unlocked but was stored within the locked room. The temperature of the room and refrigerator used to store medicines were recorded daily and were mostly within acceptable limits. We noted the temperature of the room was frequently between 24c and 26c. The recommended maximum temperature for storing medicines in 25c. Anything above this temperature could reduce their effectiveness. We spoke with the area manager about this and they said they would ask maintenance to check the air conditioning unit to ensure temperatures did not rise above 25c.

Approximately half the liquid medicines were labelled with date of opening. This is important as many of these types of medicines have an expiry date once they have been opened. However, we found some eye drops that were past their expiry date and two tubes of cream that were not labelled with the date of opening. We were informed these items were no longer in use. One of the creams was for a person who was no longer at the service and the other was no longer prescribed for the person. These should have been removed to reduce the risk of them being used for other people.

We observed the administration of medicines during the morning. In the majority of cases, this was done safely. However, we observed one person sitting at a dining table with others, who was left with their tablets, which they had tipped onto the table. Staff had not remained with the person to observe them taking their tablets. This meant staff could not be sure they had taken them and they were potentially accessible to

others.

People's medicines administration records (MAR) contained a photograph of each person to aid identification. They also included a record of any allergies and each person's preferences for how they liked to take their medicines. Handwritten MAR were signed by two people to ensure they were copied accurately. When medicines were administered covertly, the person's GP had provided their written agreement. However, there was no written evidence of consultation with the pharmacy about the decision or the person's relative. Staff told us they always contacted the pharmacy about this however, records viewed did not reflect this.

Cream administration records were kept separately in people's rooms. Records of application were more consistently completed in the two weeks prior to the inspection but prior to this were intermittently recorded. Protocols were in place for medicines prescribed to be given only as required. This provided staff with the additional information needed to ensure they were administered safely and consistently. Staff told us and records confirmed they completed medicines management and administration training and had an annual competency assessment to ensure they continued to support people safely with their medicines.

People told us they felt the home was clean and tidy. One person said, "It's very clean. It's a nice little place." A relative said, "[My family member's] room is always clean."

The home was generally visibly clean. People's bedrooms were clean and most communal areas were free from dirt. The kitchen was clean and tidy. In February 2017 the home was inspected by the Food Standards Agency and received a mark of 'Very Good'.

Staff said they had access to sufficient personal protective equipment (PPE) and we saw PPE was readily available in the home. Staff were aware of the actions to take if a person had signs of an infection such as diarrhoea or vomiting. Infection control audits were carried out along with regular reviews of any building maintenance. Actions from these audits then formed part of an on-going home improvement plan.

We did note there were some areas of the home that did require addressing to ensure the risk of the spread of infection was reduced. We saw the carpet in the entrance to the home was stained and required cleaning. We also observed a toilet by the main dining room in which the raised toilet seat was soiled and the toilet under the seat did not appear to have been cleaned for some time. The lights were not working in the ground floor sluice so it was difficult to observe cleanliness. Flooring was missing immediately in front of the washing machine in the laundry, which posed a hygiene risk, but otherwise the laundry was visibly clean. We raised these issues with the area manager who told us they would be addressed.

Reviews of the accidents and incidents that occurred took place. This also included referrals to falls specialists and occupational therapists. All decisions relating to the investigation of accidents and subsequent actions to take were made by the area manager. Where staff performance needed reviewing in light of any accidents or incidents, the area manager told us they discussed this with the staff involved. This process helped to keep people safe.

Requires Improvement

Is the service effective?

Our findings

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. We checked whether the service was working within the principles of the MCA.

We found variability in the quality of mental capacity assessments and best interest decisions. Some people who were unable to make day to day decisions in areas such as medicine administration and personal care had capacity assessments in their care plans for these decisions. However, there was not always evidence of how the decision made had been reached, who was involved and whether it had been determined whether the decision was in the person's best interest. We also noted some assessments had not been completed when needed. For example, when sensor mats or monitors were used to alert staff to people's movements there were not always mental capacity assessments and best interest decision making records for this restriction. However, we did also find some well completed examples, which clearly showed how a decision had been made. The area manager acknowledged that more needed to be done to improve people's records to show how the MCA had been applied. This would reduce the risk of people's rights not being respected. They told us they would continue to review care planning documentation to ensure the MCA was appropriately implemented for all people.

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 are called the Deprivation of Liberty Safeguards (DoLS). Records showed that DoLS applications had been made for people whose care was restrictive and amounted to a deprivation of their liberty. Copies of DoLS applications were stored in people's care records. Some of these had been authorised and staff were providing people care in line with the restrictions recorded. However, we also noted some DoLS applications made in 2016 had not yet had a decision made. The area manager showed us a central record of all DoLS applications had now been kept. They told us this would help them ensure that where there was a delay in the authorising body reaching a decision, this was followed up in a timely manner, to ensure people's rights were not unlawfully breached.

The majority of the people and relatives we spoke with told us they were happy with the way staff supported them or their family member. One person said, "I'm not unhappy here, I'm comfortable and well looked after." Another person said, "If I need anything I can ask, they accommodate me, I put my trust in them." A relative said, "Staff have got to know [my family member], they know their likes and dislikes."

Staff received an induction and an on-going training programme that covered the areas of training the provider deemed relevant to their role. This included, moving and handling, equality and diversity and safeguarding adults. Where there were some small gaps in training, records showed this had been identified and courses booked to ensure people's care was not affected by untrained staff.

Staff performance was not always monitored through regular supervision. Some staff had received up to four supervisions in 2018, whilst others had received none. Of the 47 staff employed to work at the home, 23 had not yet received supervision in 2018. The supervision matrix forwarded to us after the inspection stated each member of staff should receive a minimum of five supervisions and an appraisal per year. The area manager acknowledged that more needed to be done to ensure staff received appropriate supervision of their role. They told us now a full time manager had been recruited, they expected the supervisions to be carried out in a more timely and effective manner.

People's physical, mental health and social needs were assessed and care was provided mostly in line with current legislation and best practice guidelines. We saw information in people's care records from recognised bodies such as 'NHS Choices' about specific medical conditions and how staff should support people. However, there was an inconsistent approach to the recording of the support people received with reducing the risk of developing pressure ulcers. For example, one person's re-positioning chart was consistently completed and showed they were assisted to re-position two to three hourly as in line with the requirements of their care plan. However, for another person it was unclear how frequently staff should assist them to reposition. For example, this person's position was changed two to three hourly on some occasions but there was a gap of over five hours on one occasion and a gap of over four hours on another over a period of three days. The area manager assured us that they managed people's health conditions and in particular pressure care effectively, but agreed more consistent record keeping was needed to evidence this.

The majority of people told us they liked the food and drink provided at the home. One person said, "The food's nice, it's good food." Another person described the food as "standard fare". A relative told us staff had acted on the guidance provided to support their family member effectively with their meals.

When people had been identified as at risk of losing weight their care plans stated the frequency with which they should be weighed. However, records showed that people were not always weighed in accordance with these recommendations. For example, some people's care plans stated they should be weighed weekly but their records did not always reflect this. The records for one person stated they had been weighed twice in March 2018, three times in April, once in May and at the time of our inspection, once in June. Although these records did not show any significant weight loss during this time, the failure to weigh people in line with the recommended frequency could delay people getting the support they needed.

We noted that food monitoring charts were used to record what meals people had eaten and how much they had consumed. For some people these were completed appropriately, however for others they were not. For example, for one person we noted there were gaps in their charts and staff stated they had refused their meal, which we had seen them do during the inspection. However, the charts did not state they had refused the meal or whether a meal had been offered.

Another person who was nutritionally at risk was slowly gaining weight. However, their food charts also had gaps at tea time. We were told the person ate better at breakfast and therefore had a hot breakfast and was not always hungry at tea time. However, there was no record they had been offered food at tea time on some occasions. We were assured by the manager that people did receive their meals when they wanted them and people's nutritional risks were managed effectively, however more needed to be done to ensure people's records reflected this.

We observed people's lunchtime experience. A large menu was in place informing people of what was on offer; however there were no picture menus for those with communication needs. People were asked for their preference in the morning. However, when lunch commenced staff did not show people what food was

on offer so people who were living with dementia may have had difficulty in making an informed choice. Staff brought out individually plated meals for people. Some staff stopped and encouraged people to take a forkful of food before leaving them while they went to get someone else's meal. Some people were eating independently; others had staff supporting them fully with their meals. Others were left to eat independently with some prompting from staff. We saw some people only ate when prompted and they were left to eat independently at times with long gaps so food may have become cold.

To enable a smooth transition between health and social care services, people's care plans contained information that could be taken with them to inform other professionals of their health and social care needs. People's records explained how people communicated, whether there were any known risks to their safety and whether they had any personal preferences that should be taken into account. People told us they were able to access their GP and other health or social care professionals when they needed them. People told us told us that a chiropodist visited the home regularly. Records showed people were supported to access a wide range of external health and social care agencies when needed.

Some of the people living at the home were living with dementia and some efforts had been made to adapt the building to make it easier for people to orientate themselves around the home. There was some signage in place to help people identify their bedrooms or communal areas; however more signage was needed to further improve people's experience. The upstairs corridors, bedroom doors and carpets were a variety of colours, which helps people living with dementia to differentiate between objects. However, the downstairs space was predominantly painted white, with the same colour used for people's bedroom doors. This may prove difficult for people living with dementia orientate themselves independently of staff. The area manager told us they would review how the downstairs areas were presented to help enhance people's wellbeing.

The majority of people living at the home now lived downstairs. The ground floor had two main communal areas. These included one dining room and one lounge. Throughout the inspection we noted many people sat in the lounge area, which was at times overcrowded, especially when visitors came to see people. The first floor of the home had two further communal areas, which were currently unused. The area manager told us they were not used due to the current lower occupancy rate at the home. However, we felt people would have benefited from the option of more space by being supported to access these areas. The area manager told us they would consider this and speak with people to see if this was something they wished to access.

Requires Improvement

Is the service caring?

Our findings

People were supported by staff who did not always treat them with dignity and respect. We observed some positive interactions, however we also observed some staff speak to and treat people with a lack of empathy and dignity. For example, we saw a member of staff supporting a person with a drink of tea. They were rushing the person, rarely spoke with the person and did not engage with them on any meaningful level.

We also observed another staff member carrying out continuous supervision (also known as one to one support) with a person. During the time we observed them they did not engage with this person in any meaningful conversation or activity. Whilst the person was well cared for, there was little other than a task led approach from this member of staff.

Although staff were not deliberately disrespectful, we did observe staff speak about people in front of them and others. We noted a staff member spoke loudly across the dining room to another member of staff, referring to the person they were supporting as, "her" and "she" which was disrespectful for the person. We noted another occasion where staff also shouted across the room about people. We observed one person give a member of staff a high five and the staff member said to another staff member, "Oh (they) are in a good mood today", with the implication being this was not normal behaviour for the person. This approach was disrespectful and breached their privacy.

People's records contained information about how staff could effectively communicate with them. However, we saw staff did not always do so appropriately or respectfully. We observed staff transferring people carefully using a hoist. However, whilst they did so safely, they did not engage with the person while they were assisting them and on occasions talked with each other while they were performing the task. These examples showed staff were not always treating people with dignity and respect they deserved.

We recommend the provider ensures that staff have the knowledge and skills so that they demonstrate dignity at all times when supporting and caring for people.

We observed some positive and caring interactions from other staff who showed real empathy and a caring nature when supporting people. Whilst it was clear that staff were busy, some but not all took a minute or two to engage with people and ask them how they were. However, due to time constraints these interactions did not last much longer than a very brief conversation.

People told us they found staff to be kind and caring and they felt comfortable with them. One person said, "Staff are kind for the most part, they respond quickly and they're pleasant." Another person said, "They are respectful and maintain my dignity." People also told us they were able to have a bath or shower when they wanted to and they thought they were treated with dignity during personal care.

People looked well presented. A hairdresser was in the home on the day of the inspection and she was warm and friendly with people who clearly enjoyed their visit to the upstairs hair salon.

People told us they were able to make decisions about their care needs and this included whether they wanted a male or female member of staff to support them with personal care. Relatives confirmed they were also involved with decisions about their family member's care needs. People's care records showed efforts had been made to record people's views about their care needs with some people signing their care plans to show their agreement.

Where people were unable to make informed decisions for themselves, people had the opportunity to have an independent person to speak on their behalf if they wished them to. The manager told us if they identified any person who needed this support they would ensure they had access to an advocacy service. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are made about their health or social care. Information was available in the home should people wish to contact this service without the input of staff.

People's independence was encouraged. We observed staff support people with moving around the home, offering encouragement to people to do as much for themselves as possible. People's care records contained information about their ability to undertake some daily living tasks for themselves. Individualised guidance was also included for staff to follow when supporting people with personal care, describing how much people could or could not do for themselves.

People's care records were stored safely ensuring the information within them was treated confidentially. Records were stored in a locked cupboard away from communal areas to prohibit unauthorised personnel from accessing them. The manager was aware of the requirements to manage people's records in accordance with the Data Protection Act.

There were no restrictions on people's family and friends visiting them. We observed visitors coming and going throughout the day. Staff interacted well with visitors and made them feel welcome.

Requires Improvement

Is the service responsive?

Our findings

The majority of the people we spoke with told us there was a lack of meaningful activities at the home. Many people described themselves as being "bored". One person said, "I do get bored sometimes, I've not seen any activities." Another person said, "I don't do anything, what is there to do?"

Relatives had also raised concerns about then lack of stimulation for their family members. One relative said, "There's no recreation whatsoever, there's nothing happening for them." Another relative said, "Everything happens in this room, there's no prompting for [my family member] to go to the dining room to do anything." A third relative said, "[Family member] is safe enough here, but now they are sitting on their own downstairs for eight hours." Staff spoken with also felt more activities were needed. One staff member told us, "It would be nice to take people out on visits to external venues from time to time."

During the day of the inspection we noted there were no activities taking place. If people were not in their bedroom, they were situated in two parts of the home, the ground floor dining room or lounge. We observed people sitting in these areas for much of the day without any meaningful engagement from staff apart from day to day tasks such as providing drinks, food and supporting people with going to the toilet. Whilst people were well looked after, it was clear that there were not enough staff to support people with following their own hobbies or interests, or to take part in group activities to promote social inclusion and interaction.

There was a notice board headed, 'Activity Board' in the main entrance hall which had little information. There had been some recent activity for the royal wedding and pictures were on display. In the ground floor lounge a group of people were sat in front of the television. There were no newspapers, books or board games or any other evidence of activities around for people who did not want to watch the programme that was on. Some staff were present, but interaction was limited to ensuring people were monitored for signs of distress or discomfort rather than to engage them in meaningful conversation or activity.

One person was receiving one to one care. Their care plan stated during the person's one to one they liked cuddling dolls, having their nails done, joining in with sing a longs and listening to music. We saw none of these happening during the inspection, although they visited the hairdresser for their hair to be done. The activity record for the person for the previous day stated at 10.30am they had looked at a book with the carer, at 11.30am they had held a baby girl doll and were smiling and at 2.30pm they were listening to the radio. The staff member supporting the person on the one to one care engaged with the person for only a minimal amount of time. It was clear that there was an inconsistent approach to providing this person with the meaningful engagement they needed. Another person told us they liked to knit, but no effort had been made to support them with this.

We raised these concerns with the area manager. They told us that due to the low numbers of people living at the home, (23 out of a possible 42) the hours for dedicated activities had been reduced. Currently two members of staff had three hours per week assigned to support 23 people with activities. This was clearly not enough to ensure all people were supported with their personal interests or group activities. We were informed by the area manager that once the numbers of people living at the home increased to "27 or 28"

then 22 hours per week would be assigned to support people. The lack of meaningful stimulation and activities meant people were not being supported to lead their lives in the way they wanted to. People were also not always receiving meaningful one to one support, which could have a detrimental effect on their well-being.

People's personal preferences had been discussed with them prior to attending the home. This included their personal interests, hobbies and the things that were important to them. Little had been recently to ensure these needs were met. People's social and activity records were scarcely completed and when they were, they did not always correlate to each person's personal preferences. The lack of hours assigned for activities was minimal and staff would be unable to meet people's personal preferences and choices in this area.

This represents a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities).

Most of the care plans we reviewed contained an appropriate level of detail about people's care needs and their preferences in relation to their care. However, some would have benefited from some additional information about their health needs. For example, a person had Chronic Obstructive Pulmonary Disease (COPD). This is a term used to describe progressive lung diseases including emphysema, chronic bronchitis, and refractory (non-reversible) asthma. This disease is characterised by increasing breathlessness. The person's care plan stated they suffered from chest infections and their oxygen levels sometimes dropped very quickly. It stated their oxygen saturation levels should be checked when they had breathing difficulties but did not state what levels were normal for that person or at what level staff should take action. We noted the agency nurse we spoke with was very familiar with COPD and the action that needed to be taken. However, the action that needed to be taken should have been recorded clearly in the person's care plan to ensure that all staff would be aware of how to support the person if needed.

A person's care plan for their diabetes contained a good level of detail about the management of their diabetes and the symptoms and action to be taken in case of high or low blood sugar levels. However, we saw no evidence of an annual diabetes review, arrangements for diabetic eye screening or diabetes foot care. We did see some comprehensive care planning was also in place. For example, a person's urinary catheter care plan provided sufficient information about the management and care of their catheter.

People told us they had regular access to a bath or shower when they wanted it and were able to get up and to go bed when they chose to. People's cultural and religious needs were met at the home. People were supported to follow their chosen denomination of the Christian faith. A member of staff told us one person was Catholic and representatives from the local church visited regularly. They told us the person liked to listen to religious music in the morning and also liked Irish music. The manager told us people's diverse needs were respected at the home. Most staff had completed equality and diversity training and those that had not were booked on a course to complete it. This helped to protect people against discrimination.

The Accessible Information Standard ensures that provisions are made for people with a learning disability or sensory impairment to have access to the same information about their care as others, but in a way that they can understand. Not all information and records were presented in a way that would be accessible for all. For example, we noted the complaints procedure was presented in small print and could be difficult for some people to understand. The area manager told us they would would review the way people's records and company policies and procedures were presented to ensure they were accessible for all.

The people we spoke with were unable to tell us what the procedure was for making a formal complaint, however some told us they would talk with staff if they needed to. Some relatives told us they had been to

the manager with some concerns; however they were not always confident that complaints would be satisfactorily resolved. One relative told us they had felt the need to contact the CQC discuss concerns they had.

There was a complaints procedure posted by the front entrance to the home. However, this was seven pages long and written in small print and could prove difficult for some people to understand. The area manager told us they would review this and amend it to make it more accessible for all. The complaints register showed complaints had been responded to within the deadline as outlined within with the complaints procedure.

Advanced care plans had been developed to support people when they neared the end of their life. The information recorded in the ones we looked at was variable. One person's care plan considered actions to be taken in specific situations where the person's health might deteriorate. This included whether the person's GP was to be contacted or whether staff should seek emergency medical assistance. Some plans did not include as much detailed information but the area manager told us they were aware of this and were working towards obtaining the information needed from people living at the home and/or their relatives.

Inadequate

Is the service well-led?

Our findings

During our three previous inspections of Highfields Nursing Home we found that overall governance systems that were in place were not always effective in ensuring that the service met the fundamental standards. At each of the three inspections carried out since 19 January 2016 the overall rating for this service had been rated as 'Requires Improvement'. During this inspection we had not seen sufficient improvement to warrant a rating of 'Good', which is the minimum standard care homes should be aiming to achieve for people who use their service. When the quality of service drops below the level of 'Good' this means that some people have not received care and support that met their needs. This could cause harm to their health and safety. Due to the continued failure to improve, we have rated the key question 'Is the service Well-led?' as 'Inadequate'.

During these four inspections we have identified a number of consistent themes. People did not always receive the appropriate care to meet their needs, poor staff performance, lack of safe management of medicines, inconsistent application of the MCA and poor overall governance of the service. This has led to people experiencing levels of care and support that fall below the required minimum standards for a period of over two and a half years.

During this inspection we found some improvements had been made to the way care planning documentation and risk assessments were completed for people since the last inspection. However, this did not always translate to people always receiving the care and support they needed. We have highlighted examples throughout this report where staff had not adhered to guidance recorded within care plans and risk assessments. This had led to some people receiving care and support that could cause them harm. People's medicines were still not always managed safely and we had seen some poor attitude and approach from staff when engaging with people. Staff provided people with the basic elements of care that kept them safe, however the lack of meaningful activities and interaction had led to people becoming bored and frustrated about the lack of opportunities to take part in things that were important to them. Little has been done to address these issues.

This home has had four managers since our inspection in January 2016. This lack of stability for staff and the people they support has led to the culmination of poor performance that has led to the issues highlighted within this report. The area manager has worked hard over the past three months to provide some stability to the home by instilling new quality assurance procedures to address the concerns highlighted during this inspection. However, it was not currently possible to judge the effectiveness of these procedures or whether they are sustainable. During this inspection the area manager told us the issues highlighted to them by inspectors on the day were things they were already aware of were trying to address with the new manager who started in June 2018.

However it is clear that work was still needed to bring the quality of the service all people received to the minimum standard of 'Good' and to be able to sustain that level.

The above information was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

People and relatives we spoke with raised concerns about the management of the home, with some commenting on the number of changes that had taken place and the impact that has had on them or their relatives. A relative said, "We have spoken to the manager, the new one, they did say they would try and sort it (complaint) out. I think the place needs bringing up to standard, the management needs to get up to speed." Another relative said, "The girls are good, but the general attitude of management is poor." A third relative said, "The management would listen but not do anything."

We did receive some positive comments from people and relatives. One person told us they thought things would be better if there were more staff available. A relative said, "I have been more than happy and [my family member] would let them know if they were not."

Staff spoke highly of the area manager and the work they had carried out since managing the service from March 2018. The clinical lead told us they had been assigned set tasks when they started to work at the service, with some of their initial time spent reviewing care records and improving care plans. They recognised some improvements were required in documentation in daily records and there was an improvement plan in place. The clinical lead said they were due to meet with the area manager and the new manager to discuss their future responsibilities for auditing care. They told us they had felt very supported since starting at the service and could go to the area manager if they had any concerns.

Staff spoke highly of the area manager and described her as "fair" and "approachable". A member of staff said the area manager had, "done a lot" since coming to the service. They said, "She is a good manager, you can't fault her." They said she had initiated staff meetings and they were able to raise issues either individually or at the meetings. They told us they all had access to the minutes of the meetings.

Attempts had been made to include people in the on-going development of the service. It was acknowledged by the area manager that not enough had recently been done to obtain people's views about the quality of the service provided. We were told a questionnaire was soon to be sent out and a resident/relatives' meeting was also due to take place. We saw an advertisement for this meeting for people in the home. People we spoke with could not recall being sent a questionnaire in the past, however some relatives told us they had attended relative meetings previously, although one person told us "they are never well attended." The area manager told us they and the new manager were eager to obtain people's and their relative's views to help develop the service and identify areas for improvement, but agreed this will take time to incorporate and to act on.

Records showed there had been increased input from the provider recently in supporting the area manager to ensure people were always safe and received effective care and support. Regular meetings and telephone calls were held and the area manager was held to account for following through on the actions raised. The area manager told us they believed the introduction of the new manager and the regular input and support from the provider would see an increase in standards that would be sustainable.

The new manager was in the processes of applying to the CQC to become registered to enable them to manage the home. Prior to the new manager starting their role, the area manager had been managing the home. Both the area and new managers understood their responsibilities to ensure the CQC and other relevant agencies were notified of any issues that could affect the running of the service or people who used the service. Records showed we had received statutory notifications when required. We also saw regular reviews of accidents and incidents took place to identify any areas where people could be protected from avoidable harm.

Staff understood how to identify and act on poor practice. A whistleblowing policy was in place. Whistleblowers are employees, who become aware of inappropriate activities taking place in a business either through witnessing the behaviour or being told about it.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people and those seeking information about the service can be informed of our judgments. We noted the rating from the previous inspection was displayed at the home.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care 1) The care and treatment of service users was not always (a) appropriate, (b) met their needs, and (c) reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not ensure (2) Effective systems or processes were always in place to enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided