Crown Care IV Limited

Highgrove

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Our inspection took place on 18 December 2017 and was unannounced. We had inspected the service before, however this was the first inspection whilst being registered under Crown Care IV Ltd.

Highgrove is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Highgrove is a care home registered to provide accommodation and nursing care for up to 67 people who may have dementia care needs. The home was built in 2009, is purpose built and provides all single bedrooms with en-suite facilities. On the day of our inspection, there were 62 people living at the home.

There was a registered manager in post when we inspected. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe at Highgrove. We saw risks associated with care and support were assessed, but found inconsistencies in the quality of information in care plans.

We found processes to recruit staff were safe, and staff were deployed in sufficient numbers to respond to people's needs. Staff understood how to recognise and respond to concerns about potential abuse. People received their medicines safely.

We received good feedback about the staff's skills and knowledge, and we saw staff received regular training and support from management.

People gave positive feedback about the food in the home, however we found risks associated with people's nutritional health were not always well managed. Adapted equipment was available to enable people to remain as independent as possible with eating, and we saw people received assistance when this was needed.

The provider recognised when they needed to apply for Deprivation of Liberty Safeguard (DoLS) authorisation, however we found documentation relating to people's capacity was not always effective. We saw the provider had recognised this, and we made a recommendation about reviewing and updating this information in people's care plans.

People told us the staff were caring, and our observations confirmed this. People's privacy, dignity and independence were well supported. There was a good approach to equality and diversity principles which ensured people did not experience discrimination.

We found information in people's care plans was not always kept up to date with changes in their needs, although staff practice reflected knowledge of these.

Care plans were available in alternative formats such as larger print or braille if people required these, and arrangements were in place to ensure there was equality of access to activities. We received good feedback about the activities provided at Highgrove.

We saw complaints and concerns were resolved appropriately, and saw evidence the home received compliments from people and their relatives about their experiences of care.

We received positive feedback about leadership in the home. There was a clear vision for how the service provided care for people.

Although there was a programme of audit in place, the provider acknowledged they had identified improvement was required in this area.

People, their relatives and staff were consulted in the running of the home, and we saw a high level of satisfaction reported through survey activity.

We identified two breaches of regulation during this inspection relating to safe care and treatment and good governance. You can see what action we have told the provider to take at the back of the full version of the report.

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.

Some aspects of risk associated with people's care and support were not well managed. People told us they felt safe at Highgrove.

Staff were recruited safely and deployed in sufficient numbers.

Medicines were stored and administered safely, however some recording of medicines administration needed improvement.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider recognised documentation relating to The Mental Capacity Act (2005) required improvement. Staff had received recent training in this area as part of the provider's improvement planning.

Staff received regular training and had supervision and appraisal support from management.

Documentation relating to nutritional risks in care plans was not robust. We received positive feedback about the meals in the home, and saw there was a good level of support for people who required assistance to eat their meals.

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Is the service caring?

Good

The service was caring.

People gave good feedback about the staff and we observed friendly and respectful interactions during our inspection.

Equality and diversity principles were followed to ensure people

did not experience discrimination when they used the service.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not always reflect people's up to date needs, however staff knowledge of these was good. Health professionals said staff monitored and reported changes in people.

There was good feedback about activities in the home, and we saw people were supported to engage in these when they wished to.

Complaints and concerns were well managed, and we saw people and their relatives sent compliments about the care they received.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a programme of audits in place, however this was not sufficiently robust to effectively monitor and improve quality in the service.

We received good feedback about leadership in the home and saw there was a clear vision for delivering care.

People, their relatives and staff were consulted in the running of the home. We saw a high level of satisfaction with the service captured in surveys.

Highgrove

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 inspection took place on 18 December 2017 and was unannounced. The inspection team consisted of three adult social care inspectors, a specialist advisor nurse and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Their area of expertise was dementia care. We were also accompanied by a CQC director in an observational capacity.

Before the inspection we reviewed all the information we held about the service including action plans, past inspection reports and notifications about incidents which the provider is required to send us. We also contacted other bodies including the local commissioning authority, safeguarding teams, the fire and rescue service and Healthwatch (a consumer champion which gathers information people's experience of using health and social care services in England), to ask if they had any significant information to share about the service. We did not receive any information of concern.

We sent a provider information return (PIR), which was returned to us. A PIR is a form that asks the provider to give some key information about the service; what it does well and what improvements they plan to make.

During the inspection we reviewed records relating to care and support and the general running of the service. These included eight people's care plans, medicines administration records and daily notes. We spoke with the registered manager, deputy manager, a representative of the provider, four members of staff and the chef. We spent time making observations in the home, and looked at all communal areas and some people's private rooms. We spoke with 11 people who used the service and ten relatives. We also spoke with three visiting health professionals.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Highgrove. One person said, "I feel content here, and much safer than living on my own. There's always someone around to check on me." Another person told us, "I can press my buzzer if I need anything and they come." Relatives we spoke with gave consistently positive answers when we asked if people were safe at the home.

Care plans contained a range of risk assessments covering various aspects of people's care and support needs. These included mobility and falls, nutrition and skin integrity.

Although risk assessments were in place, we found risk minimisation actions were not always being recorded. We found there was also variable information in care plans to assist staff in minimising risk. This meant staff did not always have access to sufficient guidance to minimise risks associated with people's care and support. For example, in one care plan we saw a number of measures were listed to minimise the high risk to the person's skin integrity. These included regular inspection and recording of the person's skin condition, introduction of repositioning charts and a review of equipment such as mattresses to ensure they were appropriate for minimising the risk. The care plan did not contain any evidence these actions had been followed. This meant the provider could not always demonstrate risk was being managed safely.

We concluded the provider was in breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were able to tell us about how they would identify signs of potential abuse, and understood their responsibility to report any concerns. The provider had a whistleblowing policy in place and staff confirmed they had been told about this. We saw evidence that any incidents in Highgrove or in the provider's other homes were reviewed for any lessons learnt which could further improve the safety of people who used the service.

A visiting health professional told us they felt staff followed safe practice when assisting people to mobilise. They said, "Staff are really good with manual handling. They don't put people at risk, but they don't make people unnecessarily dependent."

We asked people whether there were enough staff at the home. A visiting relative said, "Sometimes it seems like there could be a few more staff around. They are very observant though, [name of relative]'s door is usually open and I see them walking about, they're always looking around and checking that everyone is safe and okay." Another relative told us staff were quick to respond to emergency buzzers. They said, "[Name of person] told me no sooner had they pushed it [the emergency buzzer] staff were there to sort [them] out."

Most of the staff we spoke with told us they felt staffing levels were sufficient to provide safe care and support to people, and our observations confirmed this. We looked at rotas to determine the numbers of staff in the home and how they were deployed. We saw staffing levels were maintained at a consistent level.

Safe recruitment practices were followed. Staff files we looked at evidenced background checks were made before staff started working in the home, including requesting employment references and checks with the Disclosure and Barring Service (DBS). The DBS is an agency which holds information about individuals who may be barred from working with vulnerable people. Making these checks helps employers make safer recruitment decisions.

We made checks on the management of medicines, which included looking at records, observing practice and looking at stocks of medicines and arrangements for their storage. We found staff followed good practice when giving people their medicines, medicines were stored securely, and medicines administration records (MARs) were usually properly completed.
We saw checks on the premises, including those for fire and electrical systems were made and maintenance and servicing kept up to date. We did not identify any infection control concerns during this inspection; the home was kept clean and staff had access to sufficient personal protective equipment (PPE).

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they had confidence in the staff's ability to provide effective care. One relative said, "[Name of person] must have confidence that they know what they are doing because [name] chose to come and live here." Another relative told us, "They clearly got to know [name of person] very well, even in a short space of time." During the inspection we observed staff were calm and focused when providing care. Health professionals we spoke with told us they felt staff understood how to deliver care and followed advice given during consultations with people.

There was evidence in the care plans to show risks associated with nutritional health was not consistently assessed or monitored. In one care plan we saw a person's weight loss had not been reflected in the assessment of risk. In several care plans we saw the risk assessment relating to nutritional health was not being regularly updated. This meant risks associated with nutritional health were not always managed effectively.

This evidence contributed to the breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met.

Documentation in care plans relating to people's capacity was not always sufficiently robust to show the provider was meeting the requirements of the MCA. There was a section for mental capacity; however, we could not see that formal capacity assessments had been carried out, when required. In each person's mental capacity section it gave an explanation of the MCA, but the actual description of each person's mental capacity was not decision specific. For example, in one person's care plan we saw, 'It has been assessed that [name of person] has an impairment of, or disturbance in the functioning of the mind or brain. This suggests that they have restricted mental capacity. [Name of person]'s assessment would indicate that they would be restricted in their ability to make significant decisions. When decisions, are made, [Name of Person] should be involved to the best of their ability'. In another care plan we saw the response to the question about the person having an impairment in the function of their mind or brain was, 'Possibly.' This meant assessments of people's capacity were not effective.

In another care plan information relating to the person's capacity was contradictory. We saw a statement that the person had not given consent to health and social care professionals accessing their care plan, however all other decisions in relation to consent had been made by their advocate.

We discussed our findings with the registered manager and provider. They acknowledged improvement was required, and were able to show audits where this had been recognised and plans put in place, including staff training, to address this. We recommended the provider review and update all capacity assessments as a priority.

Relatives of people who lacked capacity to make decisions such as whether to live at Highgrove told us they had attended meetings and said they felt consulted in the process. We saw some evidence of recording of best interests decisions in people's care plans.

We saw there had been recent training in the MCA, and staff we spoke with were able to tell us how they worked in ways which reflected the requirements of the legislation. One member of staff said, "We assume people have capacity to make decisions," and told us they would check the care plan for information about the person's capacity if they were not sure. Staff told us it was important to support people to make their own choices.

Records showed the service recognised when applications for DoLS authorisations were required, and we saw these were submitted in a timely way. Staff we spoke with understood the implications of a person having a DoLS in place, and what this meant in terms of the care and support they provided.

Staff told us they had a good level of support. This included induction, training and supervision meetings at which they could discuss their experience of working in the home and any development needs they had. Records we looked at confirmed training was kept up to date, and staff attended regular supervision and appraisal meetings.

The majority of the feedback we received about the meals served at Highgrove was positive, although some people expressed reservations that there was a lack of variety. One person told us, "I'm a faddy eater but they'll always fix you up with something." Another person said, "It's good food." A visiting relative told us, "There is choice with what they [people who used the service] get to have, but there's always soup and sandwiches at some point in the day." People told us they were asked for their meal choices earlier in the day, however could change their minds if they wished once they were seated in the dining room. One person told us they had asked for things to be added to the menu, and we saw this had been done.

We found the chef had a good knowledge of people's dietary requirements, such as those for people with diabetes, allergies or those who required their food to be adapted to ensure risks associated with swallowing were minimised. We saw adapted cutlery and crockery was available for people, for example for those living with sensory impairments or dementia. This meant people were supported to remain as independent as possible with eating. When we looked at care plans, however, we found information about dietary requirements was not always complete. For example, we saw in one care plan the person required an adapted diet to manage their diabetes safely, however there was no guidance for staff to indicate what foods were safe for the person to eat.

We made observations of the lunchtime service in two dining rooms. We saw rooms were well presented and observed staff chatted with people during the meal. Staff served people with their meals as soon as they were seated, and where people needed assistance to eat their food we saw this was given in a timely way. Staff asked people whether food was to people's taste or whether they wanted assistance before helping

them. Where people were given assistance we saw this was done discreetly, and with consideration for the person. The assistance was not rushed and appropriate amounts of food were offered to enable the person to eat at their preferred pace.

Care plans showed people were supported to access health and social care professionals when needed.

We discussed the environment in the home with the registered manager. We asked about planned improvements, including those to assist people living with dementia. The registered manager showed us there was a plan in place and told us they had found guidance on dementia friendly environments which they had referred to.

Good

Is the service caring?

Our findings

People we spoke with told us the staff were caring. A person who used the service said, "Everyone makes you feel welcome, even the person who does the repairs." A visiting relative told us, "The staff are extremely caring. I can go home and have peace of mind, knowing that [my relative] will be well cared for and looked after." Another relative said, "I think the carers are brilliant. They are very caring." One person we spoke with told us they were using the service for respite care, however were considering moving to Highgrove permanently due to their positive experience.

During our inspection we found there was a relaxed and calm atmosphere in the home, and found staff practice was caring. We saw staff engaged with people who used the service in friendly, respectful and sensitive ways, for example ensuring they were at eye level with the person with whom they were speaking, and giving clear explanations about any care or support they were about to give.

Staff we spoke with were able to give examples of how they ensured people's dignity and privacy were respected. These included knocking on doors and waiting to be invited into people's rooms, promoting independence and ensuring people were comfortable and could not be overlooked before commencing any personal care. One member of staff said, "I would always let people do what they can for themselves. If someone wanted to wash their own face I would hand them the flannel."

The provider had taken action to help ensure equality and diversity principles were reflected in the running of the home. The registered manager demonstrated a good understanding of how they ensured people did not experience discrimination based on 'protected characteristics' such as religion or beliefs, age, race or sexuality. They were able to give examples to show how the home was inclusive including supporting people to practice their religion and maintain important friendships and relationships.

Requires Improvement

Is the service responsive?

Our findings

We found care plans were not always completely responsive to changes in people's care and support needs, although we noted staff practice reflected up to date knowledge of people's needs. We communicated this to the registered manager at the end of the inspection. People we spoke with gave some positive feedback in this area. One relative told us, "They have clearly go to know [name of relative], even in this short space of time." Health professionals we spoke with told us they felt the staff recognised when there were changes in people and responded appropriately.

Changes in people's needs were not always clearly reflected in their care plans, meaning people may not have received appropriate care and support. For example, in once person's continence care plan it stated the person had a catheter, and then later in the plan that they experienced occasional continence difficulties. When we spoke with staff they told us the person no longer had a catheter. Another care plan stated the person experienced pain when dressing and agitation during showering. The only guidance accompanying this was related to safe ways of assisting the person to remove their dentures to minimise the risk of aspiration.

This contributed to the breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The registered manager told us people's care plans and other information could be produced in alternate formats to enable people to access them, for example in larger print sizes and braille for people with visual impairments. They told us they asked about sensory impairments or linguistic abilities which may indicate the need for information in other formats when assessing people before they started to use the service. They told us there was no one in the service that had requested alternative format documents at the time of our inspection.

Care plans contained information about the care people wished to receive at the end of thelr lives, however we found this was often generic and did not demonstrate people had been asked to contribute to this area of their care planning.

People gave positive feedback about the activities in the home. One person told us, "There's plenty to get involved with here and I'm looking forward to the Gospel Choir tonight." A visiting relative said, "There's lots for [name of person] to get involved in here, she can pick and choose what she wants to do, she never has to be lonely." We spoke with the activities co-ordinator who told us they held meetings with people to discuss things they would like to do. We saw the provider engaged with local schools, churches and voluntary organisations to provide variety in the activity programme. There were plans in place to ensure there were sufficient staff available to support people who wished to participate in activities and trips, and we saw suggestions for improving the range of activities made during resident and relative meetings were acted on.

The provider had processes in place to ensure concerns and complaints were responded to appropriately, and records we looked at confirmed these were followed. We saw the service received a large number of

written compliments about the care and support they provided. Comments we saw included, 'Words cannot express how much I appreciate what you have done for [name of person],' and 'Everyone of you are always pleasant, cheerful and so kind. You are a good team of people who really care about people.'

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post when we inspected the service. We received positive feedback from staff, people who used the service and visiting relatives about leadership in the home. The registered manager had a clear vision for running and developing the service. This included working towards each person who used the service having, "The experience they want."

People we spoke with told us they knew who the registered manager was and felt able to speak with them when they needed to. A relative told us, "[Name of registered manager] has an open door policy. I can go and discuss any worries I've got." Comments from staff included, "We all work well as a team," and "It's a nice home to work for."

We saw evidence there was a programme of auditing and monitoring in place to check and make improvements to quality within the service. This included audits of care plans, medicines, tissue viability and environmental audits. There was also a programme of provider audits, meaning there was additional external oversight of quality in the home. Although audits were being completed, they had not been sufficiently robust to identify the issues we found at this inspection. We discussed the governance systems with the registered manager and provider, and they acknowledged this was an area which required improvement.

We concluded the provider was in breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service, their relatives and staff were involved in the running of the home through regular meetings with the registered manager and annual surveys sent out by the provider.

We reviewed minutes and agendas of meetings held with people who used the service and their relatives. We saw a range of relevant topics were discussed action was taken as a result. This meant people had a voice in the running of the service.

We looked at records of staff meetings and saw these were well attended, with an agenda sent out in advance. Staff were able to add items to this agenda prior to the meeting if they wished to do so, and there was an open forum included in the agenda to capture any feedback on the day. We saw a range of topics were discussed, including complaints, training, CQC inspections at the provider's other homes, and encouragement to share good ideas for improving the care and support given to people.

We reviewed the analysis of results from the most recent resident and relatives survey, conducted in 2017. We saw there was a high level of satisfaction with the service, with 84% of people rating the home 'excellent'. Feedback showed people felt well cared for, treated with dignity and respect and helped to understand how to make complaints if this was necessary.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk was not always assessed and managed. Staff did not always have clear guidance to follow to ensure risk was minimised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems and process to make sure they assessed and monitored the quality of the service.