Care Quality Commission

Highfield Residential Homes Limited

Highfield Residential 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?	Requires improvement

Overall summary

The inspection took place on 12 and 13 May 2015 and was unannounced. Highfield Residential Home provides accommodation and personal care for a maximum of 13 people. At the time of our inspection there were eleven people living at the home. At the last inspection on 23 April 2014 we found that the provider was meeting the regulations we inspected under the Health and Social Care Act 2008.

A registered manager was based at the service. 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.

The registered manager was also one of the owners of the home and had registered as care manager in February

Summary of findings

2015. In addition to the care home the provider is registered to deliver personal care in the community from this location. This aspect of the service was included in our inspection.

People told us they felt safe in the home and we saw the registered manager and staff knew how to involve other professionals if incidents of a safeguarding nature occurred. The provider's capacity to identify risks and take preventative measures to reduce risks such as people falling was limited.

People were satisfied with the numbers of staff on duty. We saw the staffing levels had been increased in line with people's changing needs. Staff told us they felt supported but we found the induction and training of staff needed further improvement to ensure they had the skills and training to do their job. The provider had a separate staff team to support the two people who lived in their own homes.

People told us they had their medicines when they needed them. The system for checking people's medicines was not robust. We saw people were supported to have their health care needs met. Staff made appropriate use of a range of health professionals and followed their advice.

People who lived at the home told us they were happy and had been involved in discussing their care. We found further improvement was needed to ensure people were actively involved in planning all aspects of their care and developing a personalised care plan.

We observed positive interaction between staff and people who lived at the home. People told us staff were kind and patient. People told us staff respected their need for privacy and protected their dignity. Further improvements were needed in relation to assessing and supporting people's independence so that they were aware of choices they had such as looking after their own money.

Staff worked within the principles of the Mental Capacity Act 2005 by seeking people's consent before care tasks were carried out. However further consideration of the Deprivation of Liberty Safeguards (DoLS) was needed to ensure the provider had considered these to protect the legal and civil rights of people using the service where people were unable to make decisions about their care.

People told us they enjoyed the meals and we saw there was a choice of meals. More consideration was needed in relation to ensuring the mealtime was a sociable occasion for people.

The provider had a system in place for dealing with people's concerns and complaints and had followed these.

The provider did not have an effective system which allowed him to identify where improvements were needed. The opportunities for people to voice their opinions about the quality of the service were informal so it was difficult to see what changes had been made as a result of their feedback.

People told us there was little activity for them to do during the day although they had enjoyed some trips out.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People were protected from abuse and harm because staff understood their responsibilities in protecting people from the risks of abuse.

Risks to people's health and safety had not always been identified and managed.

Suitable arrangements were in place to ensure people received their prescribed medicines.

People said there were enough staff and that they were cared for by staff who understood their needs.

Requires improvement

Is the service effective?
The service was not always effective.

Consideration of the Mental Capacity Act and Deprivation of Liberty Safeguards was not effective to ensure that people's human and legal rights were respected.

Staff had sufficient knowledge and skill to meet people's needs.

People had the involvement of health care professionals to support them with their well-being.

Requires improvement

Is the service caring?
The service was not always caring.

Staff had positive caring relationships with people and knew what was important to them.

People's dignity and independence had not been fully respected and further consideration of people's social needs during mealtimes was needed.

Requires improvement

Is the service responsive?
The service was not always responsive.

People had not been fully involved in decisions about their care or supported to pursue their interests both in the home and the community.

People were actively enabled to have contact with their relatives and friends.

People told us they were aware of how to make a complaint and were confident they could express any concerns.

Requires improvement

Is the service well-led?
The service was not always well-led.

Requires improvement

Summary of findings

The systems in place to monitor the quality of the service were not effective and did not identify where improvements were needed.

People said the registered manager was approachable if they had any concerns.

Highfield Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 12 and 13 May 2015 and was unannounced. The inspection team comprised of two inspectors.

We looked at the information we already had about this provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection.

We spoke with nine people who lived at the home, one relative, the registered manager, the senior care worker, two care staff, the cook and the cleaner. We looked at the care records of four people, medicine management processes and at records maintained by the home about staffing, training and the quality of the service.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at the home. One person told us, "What's important to me is being safe in my bedroom; knowing staff are at the end of a buzzer". Another person told us, "It's all about the staff, if you've got good staff you feel safe and I do".

Staff told us that they were confident to report any suspicions they might have about possible abuse of people who lived at the home. The registered manager informed us that all staff undertook training in how to safeguard people, which was confirmed by staff we spoke with and from staff training records. Staff were able to describe to us the possible signs of abuse and how to report their concerns.

We saw five staff had recently been recruited and their files showed checks had been made before they were employed. This was to ensure that as far as possible only suitable people were recruited to work at the home.

The systems in place to manage risks to people needed improvement. For example a person had experienced twelve falls between January and March 2015. The provider had taken action following a safeguarding investigation to reduce the risk to the person. This included additional one to one staffing provided at specific times. We spoke with staff who were able to identify the risks to this person and how to keep them safe. Our analysis of the pattern of falls; to include the times and the location of the person when they fell, showed there was a pattern of falling from their chair whilst in the lounge. This indicated the supervision of people with known risks of falling was not adequate. We saw from staff meeting minutes, that the provider had taken some action to discuss with staff the importance of supervising people in the lounge but there were no systems for monitoring and reviewing accidents and incidents. The provider's capacity to identify risks and take preventative measures to reduce these risks was limited and not a proactive approach.

Risk assessment documentation was not centred on the person. For example there were risk assessments in place for the use of the stair lift but when we asked staff about particular people who had these on their file we were told they did not use the stair lift. We saw everyone had the same generic risk assessments on file which showed there was a generalised approach to risk management. There was a lack of detail in care records, for example one stated, "Needs staff support" but did not specify what this meant and was not centred on the person's needs which could put people at risk of inconsistent care.

We observed staff assisting people to move or transfer using equipment and saw they did this safely. One person told us that due to their mobility they needed to be hoisted and that this was always done by two staff to protect them from harm. The person who had suffered a number of falls had been provided with alternative seating; however the registered manager was unable to demonstrate who had assessed the recliner chair for its appropriateness. There was no update on the person's risk assessment to show the use of the recliner chair.

There were sufficient numbers of staff on duty to meet the needs of people living at the home. People we spoke with told us they were satisfied that there was enough staff to meet their needs and one person said, "We're not left waiting". We saw that staff were visible in the communal lounge areas during the day. A staff member told us, "Sometimes we do cover extra shifts if someone is ill, but the manager wouldn't let us work short of staff". The provider told us that they had increased the staff compliment to include recruitment of a cook and a domestic cleaner so that care staff were able to focus on people's direct care. We saw that staff were busy because there were some people who required a lot of support and two people cared for in their bedrooms. One person told us, "The staff are always around; they are more in the lounge now because some people might fall". Another person told us, "At night I can buzz for staff I might wait a few minutes but they come". In addition the provider is registered to deliver care to two people who live in their own homes in the community. The provider had ensured a separate staff team to support these people so that people who lived in the home were not compromised. The provider told us staffing levels were reviewed as people's needs changed. We spoke with a senior staff member who told us each shift was covered by a senior so that the delegation of care tasks, direction and support to staff could be improved.

Arrangements were in place so that medicines were available for people when they needed them. One person told us, "I get my tablets every morning and night and if I need some for pain I can ask". We saw that the senior staff member dispensing people's medicines checked the

Requires improvement

Is the service safe?

records and doses before taking them to people. We saw she offered people a drink and waited for them to take their medicines before signing the medicine records. The drugs trolley was locked between each administration which meant people's medicines were kept safe. Records showed people received their medicines as prescribed by their doctor.

Requires improvement

Is the service effective?

Our findings

We looked at whether the provider was applying the Mental Capacity Act 2005 (MCA) and the deprivation of Liberty Safeguards (DoLS) appropriately. One person's records indicated that at times they required one to one monitoring at night to keep them safe. There was no care plan detailing their behaviours although staff were able to tell us what this entailed. The person had a history of mental illness and had a previous DoLS authorisation but there was no mental capacity assessment on their file to show that the person's capacity had been assessed as to whether they could agree to this measure. Staff told us the person had 'settled now' and did not require this constant level of supervision. We also saw that a 'consent to care' form was in place; this was blank and had been pre-signed by the person's relative. In the absence of a capacity assessment showing the person lacked capacity, it must be assumed the person has capacity and as such relatives cannot give consent for a person. There was no evidence of a best interest meeting to show how decisions about the person's care had been made. The provider had not fully considered the guidance of the MCA to ensure people's rights are protected.

During our inspection we saw one person eating their lunch away from other people. We asked staff why this person was seated alone and they told us this was because the person would take and eat other people's food. We saw that staff monitored the person's movements to prevent them from approaching the people seated at other tables. The person was encouraged to sit away from the dining area whilst people finished their lunch. This person's file had no information about their mental capacity or their ability to consent to the care and support that staff offered, which was limiting their movements.

We saw that one person used a bedrail but their risk assessment for the use of the bedrail was not signed or dated. Their mental capacity to consent to the use of bedrails had not been assessed. The registered manager was unable to tell us how he checked the competency of staff to assess the use of bedrails. A person had recently been provided with a recliner chair because they had been at risk of several falls. Staff told us the person's falls had decreased and their mobility had declined so there was no further incidence of falls, and we confirmed this with accident records. We saw the person in the chair and there was no evidence this was being used to restrict their movement. However there was no mental capacity assessment in place to show if the person could consent to the use of the chair. We found no record of best interest or a risk assessment to show the appropriateness of the recliner chair being considered in line with the person's mental capacity or consideration of DoLs.

The registered manager had received training on the MCA and the Deprivation of Liberty Safeguards (DoLS). He told us he was arranging training for staff in this area to develop their understanding. There was no one in the home with a DoLS authorisation, but we found a lack of understanding and/or application of MCA and DoLs by both the registered manager and staff. Whilst we saw staff were acting in a manner they believed both supported and protected people, staff who we spoke to lacked understanding about how they would respond to people whose choices placed them at risk. Further improvements were needed to ensure that all the staff are confident about how to comply with the MCA and DoLS.

People that we spoke with told us that they were happy living at the home and with the way that staff cared for them. One person told us, "Staff knows how to care for me; I'm not so good on my legs but the staff know how to move me". Staff told us they had training in key areas to meet people's needs such as manual handling. We saw staff supported people to move safely and knew how to use equipment or aids to effectively meet people's needs. Staff spoken with told us they knew how to provide pressure care relief such as assisting people to change their position where this was needed to protect their fragile skin. Staff administering people's medicines had received training so that they were safe to do so. Staff had not received training in falls management, which was relevant as there had been a series of falls earlier in the year. The registered manager had been in post since February 2015 and told us they were reviewing the training needs of staff; we saw they had a proposed training plan in place so that gaps in staff knowledge and skills could be met. Staff spoken with told us they had an induction to be able to do their job effectively. We spoke with a staff member and found that they had not had a sufficient induction. Aspects of their role and responsibilities had not been addressed. For example they had not received food hygiene training and they were working in the kitchen preparing food.

Requires improvement

Is the service effective?

People's health care needs were met. We saw the occupational therapist assessing a person's mobility needs. People told us they had routine health checks with the dentist and optician. One person said, "I have seen a nurse regularly for my skin".

We observed a mealtime and saw that people had a choice of meals. One person told us, "They will come and tell me what's on offer and I will choose". Another person said, "The food is quite nice and they offer more if you want it". We saw staff talking to people about the meals for the day to help them decide which meal they would like to eat. We saw staff encouraged a person who was reluctant to eat; they sat with them. The person was happy to sit and eat in the company of the staff who continued to encourage them. Staff we spoke with could identify people at risk of weight loss and we saw they had been reviewed by their doctor and had access to food supplements. Records showed that people had an assessment to identify what food and drink they needed to keep them well and the cook was aware of people's dietary needs. For example food allergies people had, and who required their food to be pureed due to swallowing difficulties.

Requires improvement

Is the service caring?

Our findings

People who lived at the service were positive in their comments regarding staff attitudes and friendliness. One person commented that, "They are good; spend time chatting making sure I am alright, they care".

One person told us they liked to undertake some aspects of their personal care themselves, independent of staff; "They are patient because I know I take a while longer". Two of the bedrooms were double bedrooms which meant people shared these. Staff told us they ensured people's privacy when attending to them in their bedrooms. One person told us they liked to spend time in their room as it allowed them, "A little privacy as I like some time on my own".

We saw that when staff assisted people to the toilet they ensured they did this discretely and closed doors behind them to protect people's dignity. We saw at times that staff was not aware of the importance of protecting people's dignity where they were unable to do this for themselves. For example, one person's care plan instructed staff to ensure they wore stockings everyday as their appearance was important to them. We saw this person had their stockings on however the stockings were badly laddered which did not promote their dignity. We spoke with a staff member who told us, "Yes [name of person] likes her stockings on, oh I didn't see that", but did not make any attempt to change them. Another person had stained clothing following their lunch but was not assisted to change these until later in the afternoon. By that time this person had visitors who commented to us, "I know they are busy and I don't like to say but it upsets me they could tidy [name of person] up as [name of person] can't do it for themselves."

We saw that at lunch time little consideration had been given to the layout of the dining room furniture. This meant that people were seated facing the wall in a row with their backs to the main dining room. It was not conducive to enabling people to socialise with each other or with staff who were behind them. One person was sat alone facing another wall. There was no interaction between people or people and staff during the course of lunch which did not promote a sociable occasion. We discussed this with the manager who told us they had not considered this but would look to improve the social opportunity for people at mealtimes.

There was little evidence that consideration had been given to looking at ways in which people could be actively involved in expressing their views about their care. For example there had been no resident meetings in which information could be shared with people so that they feel they mattered and that they were listened to. The registered manager acknowledged this was an area requiring further development and told us he was planning to look at ways to involve people such as arranging coffee mornings. Relatives told us there had been no meetings where they could express their views.

People told us that their relatives were able to visit at any time and that staff made them feel welcome. We saw that relatives were welcomed by staff and staff made time to talk to relatives. A relative told us, "I come quite regular and the staff make me feel welcome and answer any queries I have". People we spoke with told us that they felt that staff knew them and were aware of their needs. One person said, "The staff know how I like things and when I need help, they are very good and patient, they don't rush me". Staff that we spoke with had an understanding of people's needs and their history and we saw they used their knowledge of the person to interact with them in a caring way. We observed that staff were respectful in their interactions and that there was plenty of humour between them and people they supported.

Requires improvement

Is the service responsive?

Our findings

People told us that staff was aware of their preferences about their care and support. One person said, "I am much happier living here because I have the help I need; I used to fall a lot and lost my confidence". People told us that they could decide what time they went to bed and got up, and what they wore. Another person said, "I can decide for myself, I have a shower when I choose". One person said, "I'm an early bird and they will always help me first thing in the morning to get up, dressed and downstairs for breakfast". However we found that people had not been fully involved in planning their care.

Care plans were not personalised and were written in a way that described care tasks with no detail about people's preferences, routines or choices. Some people told us they were able to maintain aspects of their own independence, for example looking after their own money. We saw they had been provided with lockable cash tins. However when we spoke with them and the registered manager we found that the keys to the tins were held by staff and that when money was withdrawn it was signed for by staff and not the person. We asked the registered manager if they had assessed and explored with people aspects of their independence so that their finances, medication and smoking arrangements were considered and he told us he had not. We found that further improvement was needed in relation to exploring with people their abilities and preferences and ensuring they understand the choices available to them so that they can retain control over their care and support. Further improvement was needed to ensure that people are actively involved in making decisions about their care so that staff knows their wishes.

We asked people how they liked to spend their time and if they were supported with their interests. One person told us, "There's not a lot to do here, just talk really". Another person told us, "I suppose if we wanted to do something we could ask, I don't see much happening". Staff told us that there was a planned trip to Western-Super-Mare arranged and that in the past they had organised these events. We did not observe any activities taking place during the day. Some people watched the T.V. and we saw some people regularly walked out into the garden. One person told us in the garden, "It's okay I can come out here, the staff will chat, but not a lot else happens". The registered manager told us there were no additional activity workers but care staff did activities with people. However we observed that care staff were generally busy meeting people's care needs. For the majority of the day some people remained in their armchairs sleeping and dozing between meals. People's care plans provided no information about their past hobbies or interests and we did not see that this aspect of people's care was being considered and planned for so that people had regular stimulating and fun things to do to support their well-being.

We asked people if they were supported to continue their preferred religious observances. People told us they had not been asked about this but had no desire to worship. A staff member told us they did not know if anyone had religious preferences or worshiped. It was not clear how people's religious or cultural needs had been explored as this was not recorded in their care plans.

People told us they were quite happy and confident to share any complaints they had. They told us they would speak with either staff or the registered manager who was also the owner of the home. One person told us, "He's here every day so I know him well enough to tell him off". We saw that the registered manager interacted with people during the day and was known to them on first name terms. A person who lived there said, "If I had something to say or was not happy I would tell them". Staff we asked gave an account of what they would do if someone complained to them. This included trying to deal with the complaint and reporting it. We saw that a complaints procedure was available to people and that the provider had taken account of complaints and responded to them.

Requires improvement

Is the service well-led?

Our findings

People told us they were happy at the home and that they saw the registered manager who was also one of the owners, every day. A person said, "I think it is a nice little home, it's not perfect we could do with more things to do but the staff are good".

The provider had recently registered with us as the registered manager and advised us he had recruited a senior staff member to strengthen the leadership structure. The registered manager was assisted by directors of the service. He told us he monitored aspects of the service to ensure standards were maintained but we found the monitoring systems were not effective. There was no formal process for feeding back the findings of audits and identifying if improvements were needed. For example the checks on hot water temperatures had not been carried out since January 2015. The audits related to the temperature checks of fridges and freezers were out of date and cleaning schedules had not been followed. We also saw that the recording system used in the kitchen had not been consistently completed, all of these had been audited and no errors identified which showed the audit system was not effective.

Audits of people's medications were in place to check for errors. However we found the audit system was not robust. The audit system was a basic 'tick' system. Records had not been signed by the person checking them or dated to show when they had been checked. Each month the score showed 100%. There was no record of what was checked or the numbers sampled. We discussed this with the registered manager and senior care who confirmed that there was no system in place for managers to check audits. This system did not ensure that the person carrying out the audit was competent to do so or that any random checks on the audits had been conducted to ensure they were accurate. The registered manager assured us that the system for checking people's medicines would be reviewed.

We saw food monitoring records and cleaning schedules were not consistently maintained. The cook had not had an induction and was not aware she needed to complete these checks and records. We saw fresh fruit was discoloured and out of date and kitchen cupboards cluttered and had not been cleaned even though the kitchen check record carried out by the registered manager told us these checks had been made. Staff we spoke with told us that they felt supported in their role. However we found that the induction process was not robust and the provider had not fully considered training when allocating staff roles.

All conditions of registration were met and the provider has kept us informed of all events and incidents that they are required to notify us of. Staff told us they had staff meetings and we saw one had taken place in April 2015 and had been used as a means of reviewing and improving care practices. The last senior meeting was dated 24 November 2014. There had not been a senior meeting since the registered manager took up post. He confirmed there was no formal or consistent platform for the management team to meet and discuss the service or identify where improvements were needed. The registered manager told us he fed back the outcomes of his checks on the service to the directors but there was no records of these. We found there was a need to formalise the auditing tools as those sampled were not robust or accurate. The lack of records of outcomes of checks limited the provider's capacity to monitor progress effectively. The way the service was managed did not enable the registered manager to have an oversight of risks or identify where improvements were needed.

Staff were aware of the whistle blowing procedures and how to report concerns about the conduct of their colleagues. We saw that surveys were used by the provider to obtain people's views on the service. The registered manager told us they would be looking at ways in which to feedback the analysis of surveys so that people could see what had changed as a result of their comments.

The provider had taken action to ensure they responded to the recommendations of other organisations such as the safeguarding and infection control teams following safeguarding concerns. We saw they had appointed a member of staff as the infection control lead and provided training for the lead with Dudley social services. We saw the staffing compliment had been improved by adding a cook and cleaner so that care staff could focus on care tasks. The registered manager was working to improve the records in relation to falls management and risk assessments. Whilst the provider had taken action, there was a reactive rather than proactive style of leadership whereby they could identify what was needed for themselves.