Rushcliffe Care Limited

Highfield Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

About the service
Highfield Court is a care home service providing personal care to 51 people aged 18 and over at the time of the inspection. The service can support up to 59 people with mental health, learning disability or autistic spectrum disorder.

Although registered as a care home service, Highfield Court is made up of 22 bungalows, rather than one building. The bungalows accommodated between one and six people on the day of our inspection visit.

The service was registered prior to Registering the Right Support and other best practice guidance was introduced regarding the design of care homes for people with a learning disability. The principles and values that underpin this guidance reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. People using the service did not always receive planned person-centred support that is appropriate and inclusive for them. The layout and size of the home did not fully support these principles and values.

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

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; lack of choice and control, limited independence, limited inclusion. For example people were not involved in reviewing their care. The layout of the service did not fully support people's independence and being able to engage easily with staff.

Not all people felt safe living at the home or felt their belongings were secure. Information given to staff on how to manage risks to people did not always reflect people's personalities or the reasons why they became anxious. Some people had poorly maintained bathrooms which would prevent them from being kept clean and hygienic. People's medicines were not managed safely and the deployment of staff did not support people's safety.

People did not always benefit from the use of best practice guidance in the delivery of their care. Although staff received training, they did not always have the relevant training to support people's specific health needs.

People's dignity was not always respected and they were not encouraged to be as independent as they

could and wanted to be. People did not feel listened to because there were not enough staff to spend time with them.

People did not always receive care and support which was centred around them. People were not involved in reviewing their care plans or setting goals or aspirations for themselves. People had opportunities to take part in activities, but records did not show how staff encouraged them to pursue their interests or offered them alternatives.

The provider had systems in place to monitor the quality of service provided to people. However, these systems were ineffective to ensure sufficient improvements had been made since our last inspection visit. People's care records were not always available and did not show how the service supported them to achieve positive outcomes by living at Highfield Court.

People had access to healthcare professionals and saw the GP when they needed to. The provider ensured equipment and utilities were checked to ensure they were safe to use. Staff felt supported by the management team and people's care records were kept secure. People were supported by staff to eat and drink enough to promote their health. People had access to information in a format they could understand. People had the use of an activities centre and some were supported to produce a regular newsletter.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 16 October 2018). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to insufficient staffing levels, people's consent to care and treatment not being obtained and the ineffective systems to monitor the quality of the service. We also identified that people were not protected from the risk of potential harm and the care provided was not person centred.

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

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Highfield Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was completed by three inspectors, one assistant inspector, one nurse specialist and one 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.

Service and service type
Highfield Court 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.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. This information helps support our

inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 26 people who used the service about their experience of the care provided. We spoke with eight members of staff including the registered manager, deputy manager, team leaders, care and housekeeping staff and the quality compliance manager.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, staff dependency tools, updated care records and improvement plan. We also spoke with health professionals at the local authority to share and discuss our findings.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection the provider had failed to ensure the risks relating to the health safety and welfare of people were assessed and managed. The provider had also failed to ensure accidents were always reported and the home was clean. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● People were at risk of inconsistent and unsafe care because care plans did not always provide sufficient guidance for staff to follow. Although the risks to people were assessed, their care plans often contained generic information. These did not inform staff why people may display certain anxiety related behaviour. One person spoke with us about how their mood affected their behaviour and the reasons for this. None of this information was recorded in their care plan which could give staff a better insight into how to prevent this behaviour escalating. This placed the person at an increased risk of harm.
● The registered manager told us a new electronic care plan system was introduced in March 2019. They told us people's care plans were still being put onto this new system and old care records had been archived. Therefore, information on the risks to people and how staff should support them was not always up to date or complete. This placed people at a risk of potential harm.
● Not every person living at the service benefitted from a clean and hygienic environment. In six out of 20 bathrooms, we found rusty bath hoists and bath chairs, unclean grout, missing sealant around baths and sinks and flooring with engrained dirt and yellow stains. One bathroom had mould up the wall. The registered manager told us there was an ongoing programme of refurbishment at Highfield Court and these bathrooms would soon be completed. However, these bathrooms had not been prioritised despite being a risk to service user's health, safety and wellbeing.
● The provider had records in place to monitor the cleaning of the home. However, these were not always completed by care staff.

Using medicines safely
● People's medicines were not managed safely. When staff supported people with their medicines, they did not complete the required medicine records to confirm medicines had been given safely. The medicine record was completed by another staff member who was not present. This increased the risk of medicine errors occurring.

● Where people were prescribed medicines with specific instructions, there was no records to show staff were following these instructions. One person required their medicine to be taken with food but there was no evidence to confirm this happened. This placed the person's health at risk.
● People were at risk of not receiving their medicines as prescribed. One person required their medicine as a variable dose and had specific instructions about this. The person's medicines records had been altered so staff just signed one record rather than the required two records. This did not show the person had received the correct doses of medicine and put them at risk of harm.

Systems were either not in place or not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the quality compliance manager told us the bathrooms we identified had been made a priority to be refurbished.

Staffing and recruitment

At our last inspection the provider had failed to ensure there was sufficient staffing to meet people's needs and ensure staff had the training needed to meet people's need's safely. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● People gave us mixed opinions as to whether there were enough staff to support them. One person told us told us they thought there were enough staff. Another person told us there were "definitely" not enough staff. They said, "The 1:1's (this is where person has a designated staff to support them throughout the day) get all the staff and if I need to talk they just say "oh, I'm busy just give me five minutes" and they never come back."
● Some people told us they wanted to do more during the day but there were not enough staff to help them.
● Staff told us they felt there were enough staff. However, one staff member told us about occasions when people from one bungalow would have to go into another bungalow because there were not enough staff for both bungalows. This compromised the level of care and support the individual received.
● The provider was unable to demonstrate there were sufficient staffing levels to meet people's assessed needs. The dependency tool (this is a tool to help calculate appropriate staffing numbers) in use, was not used accurately to determine safe staffing levels.
● We found discrepancies between the provider's statement of purpose, what managers told us and the actual number of staff on duty. The allocation of staff did not demonstrate how all people living at the home were supported safely at all times. For example, one night staff member was allocated one bungalow to work in. They were also required to complete hourly checks on 14 people and two hourly checks on a further six people in other bungalows.

Staff were not deployed in a way which was consistent with safe, personalised care. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection the registered manager confirmed housekeeping staff had been employed. They cleaned the bungalows where there was not a staff presence throughout the day. They told us they

encouraged people to help them and take some responsibility for keeping their own bungalow clean.

Systems and processes to safeguard people from the risk of abuse
● People told us they did not always feel safe and secure at the service. One person told us, "I came back from a weekend away and my bungalow had been unlocked. I have also been out before and come back to residents in my bedroom."
● Most staff had received training in how to safeguard people from abuse and we found a mixture of knowledge. All told us they would report any safety concerns to the management team.
● The registered manager understood their role in reporting safeguarding concerns. However, they had not recognised some practices were unsafe. For example, the management of medicines.

Learning lessons when things go wrong
● People's risk assessments were updated following incidents. One person had an incident of choking and their support and risks around food were re-assessed, to avoid this happening again.
● The registered manager told us all incidents and accidents were investigated and any patterns or trends identified. This helped to ensure appropriate responses were taken, such as health referrals or changes to staff practices.
● Staff understood their responsibilities to report incidents and accidents and we saw these had been recorded. However, due to the way electronic records were kept, it was not clear to see what actions had been taken in response to incidents or when themes were identified.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support was inconsistent.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Staff told us they had received MCA and DoLS training. However, they demonstrated lack of understanding. This compromised people's right to make their own decision.
- One staff member told us they could tell if someone did not have capacity and if this was the case, the person could not make decisions. This lack of understanding can put people at risk of being discriminated against.
- The registered persons had failed to ensure the principles of the MCA were put into practice. People's care records did not show how staff had made decisions for or on behalf of them. This included decisions around relationships and their medicines. This placed service users at risk of not having their human rights upheld.
- The registered manager agreed records relating to people's capacity should be in their care records. However, they told us this information had not been transferred to their new electronic care plans, despite this being introduced in March 2019.

This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's care and support needs were assessed and care plans were in place. Although people's care plans were holistic, they did not consider the full range of people's protected characteristics or diversity. Staff found out about people's religious beliefs but did not always discuss how for example, age, gender, culture or sexual orientation may affect how they want to be supported.
● People's care plans did not fully plan for all of their needs. One person had a health condition which gave them severe pain at times. There was no information to state how their pain may affect their personality or how staff could manage their pain.

Supporting people to live healthier lives, access healthcare services and support
● People did not always benefit from the use of evidence-based guidance in the delivery of their care. We observed some peoples teeth were in a poor condition and not clean. One persons' care plan stated they refused to go to the dentist. However, there was no information to explain how staff were to support them with keeping their teeth clean. Although managers told us they were aware of the best practice guidance for oral health, they had not put this into practice.

Staff support: induction, training, skills and experience
● People were allocated specific staff to support them. However, staff did not always have the necessary skills to support them effectively. People who lived at the service had complex learning disability and mental health needs. One person had epilepsy and was supported by a staff who had not received epilepsy training. Another person had mental health needs. They were supported by a staff who had not received mental health awareness training. This placed people at potential risk of harm.
● All staff told us they felt supported by the management team. Records confirmed staff did not receive regular supervisions with their line manager. However, staff told us they were not affected by this because they could talk with line managers and the management team when the felt they needed it.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough but we found their food choices and involvement in menu planning was varied. One person told us they wanted to get involved in cooking but were not given the opportunity. Another person told us, "The food's nice here. The staff will ask what we want for our dinner."
● People were not provided with the opportunity to purchase food and to prepare and cook their own meals. One staff member said, "Staff do their shopping. Residents don't get involved in this. They don't get involved in the cooking, but they help with the washing up."

Adapting service, design, decoration to meet people's needs
● The design of the service did not always support people's individual needs. Highfield Court is registered as a care home but the premises consisted of 22 bungalows, rather than one building. The bungalows had between one and six people living in them with some staffed and some unstaffed.
● The bungalows, dining room and office were laid out around a grassed area, with foot paths linking each. People therefore had to access the dining room and office by going outside, regardless of the weather. People had limited engagement with staff due to the layout and staffing arrangements.

Staff working with other agencies to provide consistent, effective, timely care
● People were supported to access healthcare appointments and to attend appointments with other relevant healthcare professionals, including their GP or consultants. We saw one person had been referred for assessment by a speech and language therapist following a choking incident.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People gave us mixed feedback about whether staff were caring towards them. One person told us, "Some are kind yes, caring no. They shout at you for no reason and they've got no time for you." Another person told us, "I do (think staff are caring). They help me out and are very kind to me."
- The registered persons had shown a discriminatory and generic approach in the support of people with learning disabilities. People's medicine records stated they could not administer their own medicines, "due to learning disabilities". The registered manager told us this was the case with everyone living at Highfield Court. However, people's ability to self-administer any of their own medicines had not been discussed with the person, considered or assessed.

Supporting people to express their views and be involved in making decisions about their care

- People did not always feel listened to or in control of their own care. One person said, "There's no one to talk to or listen to you, because there's just no staff." Another person said, "I think they could improve by spending time with us. It would be nice to have a chat and a cup of tea and ask how my day or night has been."
- For people who did not have a staff member allocated to their bungalow, we saw most spent their day watching television or walking around the grounds. People congregated around the office building and tried to get staff's attention through the windows. If the window was open, staff often closed it, which cut people off from any engagement with them. One person said, "Sometimes I go to the office to find staff and there are four or five sat in there chatting and they don't have time to talk to me."
- Not everyone we spoke with felt they were enabled to participate fully in making decisions about their care. However, people praised staff when they did spend time with them. One person told us, "[Staff member's name] is amazing, they understand me. They can calm me down and they don't judge me"

Respecting and promoting people's privacy, dignity and independence

- People told us they wanted more independence and wanted staff to encourage them more. We saw people who ate their meals in the dining room waited to be served by staff. This was despite some people having the ability to and wanting to make their own meals.
- The registered manager had not ensured people's dignity was maintained. Some people were unkempt with body odour, poor oral care and wore dishevelled and unclean clothes. Although some people were more independent than others, staff had failed to encourage everyone to maintain a dignified appearance.
- Most staff went into bungalows and people's bedrooms only after knocking and announcing themselves. However, we did see some staff who did not.

● People's care records were treated confidentially. Records kept electronically were password protected and paper records kept locked away when not in use.

Requires Improvement

Is the service responsive?

Our findings

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

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People did not receive a fully person-centred service which was flexible to their different needs. One person told us they wanted to cook their own meals in their bungalow but were not given the opportunity. Their care plan stated they could not do this because of their health condition. However, the registered manager told us this person's ability to cook with staff support had not been explored.

● People told us they did not feel involved in the planning or review of their care plans. One person said, "I haven't seen my care plan since it went electronic (in March 2019)."

● The provider's statement of purpose told people their care plan would be reviewed at least once a month, with their involvement and agreed and signed. People we spoke with confirmed this did not happen.

● People's care plans did not contain information on their goals or aspirations. People's life experiences were not used to introduce future goals for them to work towards. This shows a lack of person-centred planning and delivery of care.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People gave us mixed feedback about the support they had to pursue hobbies and interests. Some people told us they did not want to do anything. Other people told us they wanted to do more, but nothing happened at the service which interested them.

● One person told us they had "odd jobs" given to them by the cleaners. Another person told us they wanted to go out more but there was not enough staff to support them to do this. We saw people walking around the grounds or sat in their bungalows with no or little interaction from staff. One person said, "I sleep all day because there's nothing to do."

● Records which staff completed did not show how people were encouraged to pursue either normal daily activities or activities which were meaningful for them. Records we saw showed staff focused on recording the fact that people had eaten and had taken their medicines.

People did not receive care which was wholly person-centred. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us there was an activities centre on site which some of them used. We saw activities included keep fit sessions, singing and a choir and trips outs. Some people had been to the circus the day before our inspection. People also contributed to a monthly newsletter which they proudly showed us.

Improving care quality in response to complaints or concerns

● Not everyone we spoke with knew how to make a complaint if they wanted to. Most people we spoke with told us they knew how to raise a complaint.
● The provider had systems in place to record and investigate and to respond to any complaints raised with them.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The provider was meeting the standards for the AIS. People's communication needs were assessed and their care plans gave staff information on how best to support their communication.
● The registered manager told us information was able to be provided to people in alternative formats when they required it.

End of life care and support
● The registered manager told us they had not fully explored people's preferences and choices in relation to end of life care. They told us this was mainly due to most people being younger adults. However, the registered manager confirmed this had started to be discussed with people so staff could identify their wishes.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in the service. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to ensure their quality systems were effectively identifying concerns and driving improvements at the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

- The registered persons had failed to ensure improvement within the service. This was the third consecutive inspection where we found this key question had not met the expected standards.
- The provider and the registered manager had not provided effective oversight and governance of the service's safety and quality to ensure all regulatory requirements were met.
- The provider's quality systems failed to recognise staff were not following the system in place for safe medication administration. The registered manager told us medicine audits were completed regularly. However, these audits had failed to identify the serious issues we found with medicines throughout our inspection. The registered manager was unable to provide evidence to show staff's competence to administer medicines had been assessed. We also found staff did not follow the provider's medicine policy due to the medicine arrangements at the service. This included the training staff should have and how they recorded the administration of medicines.
- The provider's quality systems had failed to identify people's records were not up to date or complete. The management team told us the provider introduced a new electronic care record system in March 2019. Although some of people's care records had been transferred to the electronic system the process was not complete. The registered manager also told us a lot of people's care records had been archived, so records we asked to look at were not made available to us. Therefore, information on people's risks, assessments and needs was not complete. This placed people at risk of harm as staff and visiting professionals will not have a full picture of people's care and support needs.
- The provider's quality systems had not ensured some people's safety and wellbeing were considered or assessed. One person's care record stated they needed 24hour support and supervision. We found this person alone in their bungalow and we were told it was "OK" for them to be left alone. No risk assessment was in place to mitigate any risk when they were left alone. We made a referral to the local authority about

this to pass on our concerns. The local authority agreed to arrange an urgent care review for this person.
● The provider had failed to ensure records relating to decision making under the MCA had been completed and were accessible. This placed people's safety at risk due to their human rights not being protected.
● The provider had failed to ensure bathrooms were prioritised for refurbishment. Some people continued to live in an environment which was poorly maintained and posed an infection risk despite audits and cleaning checks taking place.
● The registered manager had failed to ensure all audit records were completed, reviewed or actioned. We looked at the cleaning records kept in each bungalow. These were not always completed and some records showed bungalows had not been cleaned for months.
● Feedback from people who used the service was mostly positive about the staff who supported them. However, people did not always feel their quality of life and wellbeing were improved by living at Highfield Court. One person told us, "This place isn't for me, but it's somewhere safe."
● The provider's statement of purpose was last updated July 2019. We found the provider's delivery of care did not always match their philosophy of care. This included people being involved in monthly reviews of their care and the health and medical conditions they supported.
● At the start of our inspection, the registered manager confirmed they supported younger adults and older people in the following service user bands; mental health and learning disability or autistic spectrum disorder. However, during our inspection we found the service also supported people with sensory impairment, physical disability and misused drugs and alcohol. We ask providers to inform us which service user bands they operate within. This is so we can make sure providers have staff with suitable knowledge, skills and experience to meet the needs of people in each of those service user bands.
● The registered persons had not ensured the culture of the service fully supported the aims of national guidance for supporting people in care homes and with learning disabilities, such as Registering the Right Support.

The provider's quality assurance systems had failed to ensure continuous and sustainable improvement within the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Links with the local community were limited. One person told us they attended a local community group where they took part in craft, gardening and cooking. They told us they really enjoyed this.
● People were invited to take part in monthly residents' meetings. Although these were successful in engaging the people who attended, at the last meeting only 12 people attended. The registered manager told us it was the same people who attended the meetings, therefore they used 'satisfaction surveys' as another way to seek the views of people.
● Not all people were able to contribute to 'satisfaction surveys'. The recent survey showed people were mostly positive about the service they received. However, this survey involved people and relatives from another one of the provider's homes, not just Highfield Court. The provider had also acknowledged the response rate was lower than last year and this was likely to be because they supported people, "with a range of complex needs, who may find it difficult to understand and respond to the survey". Despite this, not all people had been included or supported to contribute to this survey.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood their regulatory responsibilities. Incidents and concerns were recorded and relevant professionals informed as required, such as the local safeguarding team, health

professionals and us.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure service users received care which was person centered and promoted their independence.

The enforcement action we took:

We have imposed conditions for the provider to address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure service users' rights were promoted and supported through effective decision-making processes.

The enforcement action we took:

We have imposed a condition for the provider to address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the proper and safe management of service users' medicines.

The enforcement action we took:

We have imposed a condition for the provider to address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure an effective governance system to monitor and provide continuous improvement in the quality of care for service users. This was a continued breach of Regulation 17.

The enforcement action we took:

We have imposed conditions for the provider to address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure service users received person centred care and support because there were not always enough staff to help them.

The enforcement action we took:

We have imposed conditions for the provider to address this breach.