Highcliffe House Limited

Highcliffe House Nursing Home

Inspection report

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15 July 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

This urgent, focused inspection took place on the 15 July 2016 and was unannounced.

We carried out this focused inspection to look at concerning information in response to a serious incident that had occurred the day before resulting in a fatality.

Following our previous comprehensive inspection in May 2016, we asked the provider to take action to make improvements as we found evidence of major concerns in relation to a lack of regular, effective quality and safety monitoring of the service. The provider's audits were found to be sporadic, irregular and did not identify the shortfalls we found in relation to qualified nurses management of people's medicines and inadequate medicines management policy. There was no clear, established system of clinical governance in place and operated effectively with regularity which would ensure regular assessment and monitoring of risk in relation to the regulated activity which included nursing care.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

Highcliffe House Nursing Home is a 30 bed residential and nursing care service providing care, treatment and support, including end of life and care and support for people living with dementia.

There was a registered manager who was also the registered provider. 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. However, as this is a care home with nursing we found that there was no clinical lead with overall responsibility for clinical governance of the service.

During this urgent, focused inspection 15 July 2016, we found a continued failure to ensure that service users were protected from the risks associated with improper operation of the premises, with a failure to assess the risks to people's welfare and safety. We found that the provider had made no attempt to carry out any environmental risk assessments and no individual assessments in relation to people with access to windows without appropriate window restrictors in place.

We also found a lack of action to assess the risks to people's welfare and safety as the provider had made no attempt to carry out any environmental risk assessments and no individual assessments in relation to people's exposure to the risks associated with contact with hot surfaces such as unprotected radiators.

An external health and safety audit was carried out in February 2015, commissioned by the registered person. Recommendations for action following this audit included; accidents and incident statistics should be reviewed and outcomes with actions recorded on a formal basis. The audit report also highlighted the

need for health and safety training to be provided for all staff including risk assessment and that suitable and sufficient risk assessment for all activities where there is a risk of injury should be carried out. Target dates for signatures to evidence actions taken were not completed. The registered person was not able to show that actions had been taken in response to this audit.

This meant that the safety and welfare of people using the service was at risk and the provider was failing to identify risks and provide a safe service. The provider was not meeting the requirements of the law as they did not protect people against the risks of receiving care or treatment that was inappropriate or unsafe.

This report only covers our findings in relation to this urgent, focused inspection which we carried out in response to having received concerning information. You can read the report from our comprehensive inspection carried out 3 May 2016, by selecting the 'all reports' link for 'Highcliffe House Nursing Home' on our website at www.cqc.org.uk

During this inspection we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

The service was not safe.

People had been placed at risk as the likelihood of harm from access to unrestricted windows and access to hot surfaces from unprotected radiators had not been assessed. Risks assessments had not been produced to guide staff in how to mitigate these risks and keep people safe from harm.

The provider had failed to take action in response to recommendations made following external health and safety audits.

Is the service well-led?

Inspected but not rated

Not assessed at this inspection.

Highcliffe House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 urgent, focused inspection took place on the 15 July 2016 and was unannounced.

This inspection team consisted of two inspectors

Prior to our inspection we received concerning information about the service provided. Also prior to our inspection we spoke with stakeholders, including the police.

We reviewed care records for two people. We also reviewed records in relation to the quality and safety, management monitoring of the service.

During our inspection we spoke with the provider, the nurse consultant, the handy person and a nurse.

Inadequate

Is the service safe?

Our findings

At our previous comprehensive inspection of Highcliffe House Nursing Home on the 3 May 2016, we found evidence of major concerns in relation to the quality and safety monitoring of the service.

At this urgent, focused inspection 15 July 2016 we carried out a tour of the premises. We looked at all the windows within people's rooms. 29 Rooms in total. We found that all of the eight windows on the second floor opened outwards with a gap of up to 50cm and did not have appropriate window restrictors in place.

One bedroom on the 1st floor had been fitted with a window restrictor but did not open any more than 1cm. The window was restricted to an insufficient gap and did not allow for sufficient flow of fresh air. Another window fitted with a window restrictor did not open at all and staff could not locate any key.

Two windows on the ground floor were fitted with chain restrictors. The chain restrictors were not robust enough to withstand reasonable force. This meant that restrictors fitted were not in accordance with recommendations as per the Department of Health, Health building note 00-10 Part D: Windows and Associated Hardware 2013 guidance for Health & Social Care settings.

We found that the provider had made no attempt to carry out any environmental risk assessments and no individual assessments in relation to people with access to windows without appropriate window restrictors in place. We found that the majority of the windows within the service had windows which did not have appropriate window restrictors in place. This meant that no assessment of risk had been carried out on behalf of people who may be at risk of attempting to leave an environment they perceive to be hostile, or use a window, believing it to be an exit, unaware that they are not at ground level, falls out of windows arising out of a confused mental state and those intending to deliberately self-harm.

We found that the last 'window safety' monitoring audit was carried out by the provider in September 2004. This covered relevant issues but is no longer relevant and out of date by 12 years.

Where window restrictors had been fitted these were not subject to any formal, planned and recorded preventative maintenance and monitoring schedules. This was confirmed by the registered provider and the maintenance person employed by the registered provider

We found that the provider had made no attempt to carry out any environmental risk assessments and no individual assessments in relation to service users exposure to the risks associated with hot water surfaces including the risks associated with hot surfaces such as unprotected radiators. This was confirmed by the registered provider and the maintenance person employed by the registered provider.

Although the handy person carried out checks on water temperatures from outlets there was no monitoring in place to assess the risk of scalding from un-protected radiators. Relevant guidance was not adhered to, which also describes the necessary requirements and rationale for them. People with restricted or impaired mobility are at risk of burns from unprotected radiators if they fell against them and have prolonged contact.

Such incidents can occur where there are low levels of supervision for example in bedrooms and bathrooms.

At this urgent, focused inspection we found a health and safety audit which had been carried out by an external organisation in February 2015 and commissioned by the registered person. Recommendations for action included; accidents and incident statistics should be reviewed and outcomes with actions recorded on a formal basis. The audit report also highlighted the need for health and safety training to be provided for all staff including risk assessment and that suitable and sufficient risk assessment for all activities where there is a risk of injury should be carried out. Target dates for signatures to evidence actions taken were not completed. The registered person was not able to show that actions had been taken.

This demonstrated a breach of Regulation 12(1)(2)(a)(b)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

Is the service well-led?

Our findings

No assessed at this inspection.