Highfields Limited

Highfields Nursing Home

Inspection report

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Nottinghamshire
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Highfields Nursing Home is a residential care home providing personal and nursing care for 30 people aged 65 and over at the time of the inspection. The service is registered with CQC for up to 42 people.

Highfields Nursing Home accommodates people in one adapted building over two floors. There are various communal areas for people to sit and relax.

People's experience of using this service and what we found
The service was not clean and hygienic. There had been a shortage of domestic staff and the workload had fallen on staff and the management team. Audits of cleaning were out of date.

Infection control standards were poor due to the lack of cleaning. There was a lack of management checks on cleaning and environmental safety.

Medicines management and administration was not always safe. Medicines audits to identify errors or issues were out of date.

There had been nursing staffing shortages and the registered manager had been forced to cover clinical shifts. This meant they were not able to perform all their management duties and quality monitoring of the service had fallen behind.

Incidents and accidents were not always analysed, as a result, the opportunity to identify themes and trends and learn lessons was missed.

Staff meetings did not take place and staff told us they felt overworked and undervalued by the provider. Staff performance was not monitored. Staff, people and relatives were not asked for their opinion of the service.

It was not clear if all staff training was up to date due to the complex nature of the training matrix in place.

Quality monitoring processes and systems in place were not up to date and there was a lack of ongoing improvement in place.

Processes to monitor people's standards of care was not clear and we found gaps in recording that had not been addressed. People mostly had comprehensive care plans in place with risk assessments. We found one that was out of date.

The service worked in partnership with other organisations to support people.

People told us staff were kind, available to them and knew what they were doing.

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

Rating at last inspection
The last rating for this service was Requires Improvement (published 30 April 2019).

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We received concerns in relation to the management of people's nursing care needs, the reporting of falls, and a lack of reporting. As a result, we undertook a focused inspection to review the key questions of Safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the Safe and Well-Led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

Following our inspection, the provider has taken action to mitigate some of the concerns we found.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Highfields on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to Regulation 12 Safe Care and Treatment and Regulation 17 Good Governance at this inspection.

Follow up
We will request an action plan and meet with the provider following this report being published to discuss how they will make changes to improve the standards of quality and safety. We will work alongside the provider and with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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 the 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?

Inadequate

The service was not Safe.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not Well-led

Details are in our Well-Led findings below.

Highfields Nursing Home

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors on site and an Expert by Experience making phone calls off site. 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
Highfields is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that 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 inspection
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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection. We contacted Healthwatch, Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection
We spoke with three people who used the service and 12 relatives about their experience of the care provided. We spoke with 11 members of staff including the registered manager, deputy manager, registered nurse, senior carers, carers, domestic staff, maintenance staff and the chef. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included six people's care plans, multiple medicines charts, staff training, staffing levels, and meetings. We reviewed recruitment records of three staff and supervision and training records. 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 policies and procedures.

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 deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Poor oversight of care meant people were at risk of neglect. Records of people's weight were not maintained as recommended. People who had instructions in their care plans to have their weight checked weekly due to weight loss, were not weighed weekly. The management team told us they had oversight of this on the computerised care records, however it was not clear how this was monitored or addressed, due to the gaps we identified.
- We identified gaps in food and fluid records of people who were at risk of weight loss, again it was unclear how the management team had identified and actioned this.
- Records of repositioning were not always maintained and again, we found gaps in record keeping that were not addressed.
- Failure to maintain oversight of people's basic care put them at risk of neglect.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People's risks were assessed, and care plans were in place. However, we reviewed one person's care plan, who did not have an up to date risk assessment for their mobility. Their mobility care plan and personal emergency evacuation plan were also not updated. This meant staff may not know how to support them to mobilise safely. Documentation audits had not been performed to identify these issues.
- There was a lack of monitoring of environmental issues to keep people safe. The registered manager told us they walked round the service however, this was not formally recorded to show spot checks on staff or health and safety findings and actions taken.
- We found two store cupboards unlocked, the kitchen door was left open. A cleaning trolley was left unattended. This put people at risk of accessing items that may not be safe for them.
- Opportunities to learn from incidents and accidents were missed. There was a lack of analysis of falls, accidents and incidents to identify trends and learn lessons to prevent reoccurrence. The management team told us that their monitoring of incidents had fallen behind due to staffing shortages.
- Staff told us they were not given feedback on incidents or safeguarding events to learn from. One member of staff told us, "I don't know how incidents are reviewed".
- Failure to monitor environmental safety and perform documentation checks put people at risk of receiving unsafe care.

Staffing and recruitment

- Staff told us there were not always enough staff to spend time with people and staff sickness had an impact on this. Staff told us they were exhausted and stressed.

● The service had had difficulty recruiting a registered nurse and the registered manager had been covering shifts if there was no agency staff available. The management team had also been trying to cover domestic staffing shortages. This meant they were not always able to perform their management duties.
● We observed that there were not always enough staff in communal areas, those staff that were present did not always observe people effectively. This put people at risk of falls and avoidable harm.
● Despite having an activity coordinator in place, there was a lack of activities going on in the home.
● It was unclear to us, what training staff had received. Training compliance was 86%. Some people at Highfields were living with epilepsy, we could not see from the training record if staff had received training in epilepsy to support people safely.
● The management team and staff had been cleaning the premises, we found floors and carpets were sticky.

● Staff performance was not monitored effectively, and staff appraisals and supervisions had fallen behind. This meant that staff may have missed out on opportunities to learn, progress and improve their practice.

Using medicines safely
● Medicines were not always managed safely. Medicines administration records contained loose sheets of paper that could fall out or be put in the wrong section. Not all profiles had photographs of people. 'As required' medicines protocols were not reviewed in the specified timescale.
● Medicines were not disposed of in a safe and timely way. A container for medicines for disposal was full and medicines were piling up in a container on the floor.
● Some people were receiving medicines covertly. There was a lack of covert medicines guidance kept with the medicine's charts, guidance was kept elsewhere. This meant agency staff may not know how to administer covert medicines in the prescribed way.
● Senior care staff told us, "We get disturbed all the time when doing medicines". Interruptions whilst administering medicines meant errors were more likely to occur.
● One person was taking a medicine unsupervised, but there was no risk assessment in place for this to ensure they were taking it correctly.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through hygiene practices at the premises. There had been a shortage of domestic staff to perform the cleaning and we observed furniture and equipment to be visibly soiled.
● Cleaning schedules and audits were not up to date. There were no formal checks available on equipment cleaning.
● We were not fully assured the provider was facilitating visits for people living in the home in accordance with the current guidance. We observed one visitor in the home with their relative, not wearing a mask.
● The hot water supply in some areas of the home took a long time to reach a suitable temperature for staff to wash their hands in a timely way.
● We were not fully assured the provider was using personal protective equipment (PPE) effectively. Some of the PPE stations were not fully stocked and sluice rooms did not always have goggles in place to protect staff.
● We found jugs and urinals in bathrooms and sluice rooms; these were not labelled to identify who they belonged to which put people at risk of cross contamination. Not all bins were covered, and we found PPE disposed of in non-clinical bins.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

The provider responded immediately during and after the inspection. The registered manager informed us new tables and chairs had arrived and domestic staff had been recruited to full complement of staff.

- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

- Recruitment processes were safe to ensure suitable people were employed to work at the service.
- People told us they were happy living at the service. One service user we spoke to told us, "Carers are lovely, very kind, they never make me wait." Another person told us, Staff are always available, and know what they are doing, carers and the registered manager are lovely."
- We observed nice interactions between staff and people living at the service.
- Staff were up to date with safeguarding training, and staff we spoke with were aware of how to report concerns.
- Staff compliance with infection control training was 100%.

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 now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. 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

- Quality assurance measures were not being used to monitor the quality of the service to drive improvement.
- The provider had quality monitoring systems and processes in place. However due to staffing vacancies the management team had not had time to perform these and told us they were two months behind with their audits of documentation, pressure damage, medicines, infection control, mattress checks and cleaning. This meant they were unable to identify and put improvements in place in a timely way.
- Staff informed us that they did not have time to perform their roles and they felt unsupported and under pressure due to staffing vacancies across the service. A member of staff told us, "We are covering other people's work".
- The management team told us they had also fallen behind on monitoring staff performance to identify improvements. We spoke with two staff that had not had supervision since they started at the service.
- The management team told us they could view staff training and received weekly updates from head office. However we found it difficult to analyse the training information due to the way it was presented.
- The provider did not visit the service to check on the quality of care or perform audits. The management team told us they used to be supported by an area manager, but following changes in head office, this had reduced, and their workload had increased. There had been changes to systems without the necessary training, and these processes had then been removed.
- Accidents and incidents were not fully analysed for themes to identify how to put improvements in place. Staff told us they were not informed of the outcomes of investigations, accidents or incidents. This put people at risk of receiving poor care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff told us they were stressed and overworked and did not feel listened to or valued. Staff told us the management team tried to support them, but they were also overworked.
- Staff told us they had raised concerns about staffing and the challenging behaviour of some people living at the service, but nothing was done to improve things.
- Staff told us the provider had not visited the service for over a year. One staff member told us, "I have never met them, they have not been in since the pandemic started". Another member of staff told us, "The care is great, but morale is low."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff told us meetings were infrequent and the management team told us attendance was poor. There were no meetings for people living at the service or their families to share information or gain their opinions. There were no recent surveys to staff, people or relatives to gather feedback on the service and identify improvements.

● Staff told us they did not feel valued by the provider and when they tried to raise concerns they were not listened to.

We found no evidence that people had been harmed however, due to poor governance people were placed at risk of harm. Systems and processes to monitor the quality of care and monitor staff were not being followed. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we were informed that staffing gaps had been filled. The registered manager took immediate action to catch up with audits. We received audits they had recommenced, analysis of incidents and minutes of meetings they had organised after our inspection.

Working in partnership with others

● The service worked with different organisations to support people, records we reviewed identified the different organisations that were involved in people's care.

● The registered manager told us they conducted a weekly ward round with a GP to identify people's changing needs.

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

● People's relatives told us they were informed if accidents happened.

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