Burlington Care (Yorkshire) Limited

Highfield Care Centre

Inspection report

Allerton Bywater
Castleford
West Yorkshire
WF10 2DY

Tel: 01977552601

Date of inspection visit:
28 July 2020
29 July 2020
30 July 2020
03 August 2020
04 August 2020

Date of publication:
01 September 2020

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Highfield Care Centre is a 'care home' which provides accommodation and personal care for up to 88 older people some of whom may be living with dementia. At the time of the inspection there were 53 people using the service. Accommodation is spread out over four distinct units of the home. At the time of the inspection three of these were in use.

People's experience of using this service and what we found
People and relatives provided good feedback about the service and told us that good outcomes were experienced. We found staff were kind and caring, treated people well and there was a person-centred culture within the home.

We identified infection control and cleaning practices did not always promote safe care. COVID-19 personal protective equipment (PPE) requirements were not consistently followed, and some areas of the home were unclean. Some improvements were also required to the medicine management system to provide assurance that medicines were consistently managed in a safe and proper way.

In most cases, risks to people's health and safety were properly assessed and managed. Measures were put in place to help prevent accidents such as falls. Detailed analysis took place following any untoward events and we saw there was a culture of learning from adverse events.

People said they felt safe and safeguarding procedures were in place which were well understood by staff. The building was safely maintained and was in the process of being refurbished.

There were enough staff deployed to ensure people received prompt care and support. We observed communal areas were appropriately supervised. Staff were recruited safely and received a range of training.

Whilst the overall rating for the service has deteriorated since the last inspection in January 2019, we felt assured that over the last few months improvements had been made in some areas. A number of new systems and processes had been put in place which demonstrated that risk was better managed, new training and guidance had been provided to staff and working relationships with others had improved. These improvements need to continue and be sustained and further improvements are required in respect of medicines management and infection control practices.

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 Good (published 14 February 2019).

Why we inspected

The inspection was prompted in part due to concerns received about risk management and safeguarding within the home. As a result, we undertook a focused inspection to review the key questions of 'Is the service safe?' and 'Is the service well-led' only.

Prior to this inspection, 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 good to requires improvement. This is based on the findings at this inspection. We found evidence that the provider needs to make improvements. Please see the 'Is the service safe?' and 'Is the service 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.

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

Enforcement
We have identified one breach of regulation. This was in respect of the provision of safe care and treatment, specifically in relation to infection control and medicines management. Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below

Highfield Care Centre

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.

This was a focussed inspection to check safety and leadership within the home following a number of safeguarding concerns received about the service over the last year. These concerns related to the service's ability to manage and learn from incidents and accidents.

Inspection team
The inspection team consisted of four inspectors, one of these being a medicines inspector and an 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. The medicines inspector and Expert by Experience supported the inspection remotely using video conference facilities to speak with the management team and people who use the service.

Service and service type
Highfield Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with CQC. 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
We gave the service 45 minutes notice of our inspection. Due to the COVID-19 pandemic, we needed to check the COVID-19 status of the home and make arrangements to enter the home safely to reduce the risk of infection transmission.

Inspection activity started on 28th July 2020 when we visited the care home and ended on 4 August 2020. Following the site visit, we spoke with people and relatives, staff and the management team using telephone or video conferencing facilities and reviewed documentation sent to us by the provider.

What we did before the 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 of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and four relatives about their experience of the care provided. We spoke with eleven members of staff including the regional manager, registered manager, deputy manager, care workers and domestic staff. 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 four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, audits and cleaning schedules were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was not complete assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection
• During the site visit, we identified improvements were needed to infection prevention and control practice. Some staff were not wearing the required type of face masks or wearing them correctly. Whilst staff had access to the national guidance, COVID-19 risk assessments needed to more specific. For example, they needed to set out the PPE requirements and required working practices for each staff group and visitors to help reduce the risk of infection and prevent the inconsistent practice we observed.
• Whilst many of the areas of the home were clean, this was not consistently the case. We identified the dining rooms in the Kensington and Sandringham units had not been cleaned to a satisfactory standard. Cleaning schedules were also not consistently completed and indicated staff had not been available to clean the home on some days. The service also needed to evidence that enhanced cleaning was in place as a result of the COVID-19 pandemic, for example cleaning of frequent touch points within the home and ensure domestic staff were provided with clear instructions on what additional cleaning to undertake and how frequently.

Whilst we did not identify a direct impact on people there was a chance of harm if high standards of infection control were not followed. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

The provider responded positively by taking immediate action to address these concerns. For example, by undertaking supervisions of staff and making managers walkarounds and checks on cleaning schedules more robust.

Assessing risk, safety monitoring and management
• In most cases, risks to people's health and safety were properly assessed and managed although some care plans had not been kept up-to-date. For example, two people's care plans had not been updated following safeguarding incidents to demonstrate the preventative measures put in place. Immediate action was taken to address this during the inspection. Other care plans were better with detailed information recorded and staff were generally knowledgeable about the people they were caring for. The service worked with professionals to reduce the risk to people, for example around skin integrity.
• The service took action following falls to help reduce the risk of re-occurrence. This involved updating care plans and risk assessments and working with other professionals to put preventative equipment in place such as sensor mats. In-depth falls prevention training was also being provided to staff. Whilst we saw improved systems were in place to check equipment was operating effectively, we found one person's chair sensor had gone missing twice since December 2019. We spoke with the manager about the need to ensure

better oversight of this equipment.
• The premises was safely managed with the required maintenance checks undertaken to help keep people safe.

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of abuse. Whilst there had been a number of safeguarding concerns over the last 12 months, the management team had put in place measures to improve safety. There had been a reduction in incidents in recent months and there were improved systems to reduce the risk to people. One relative said, "the place has been wonderful, when [person] first when in there [person] was displaying quite challenging behaviour and it was distressing. They have worked with [person] and [person] is much more settled."
• People told us they felt safe and secure in the service. Staff had received training about their safeguarding responsibilities. They received regular management updates about safeguarding and related topics, to help reduce the risk of harm to people. Staff we spoke with knew how to identify and report abuse and were aware of incidents that had happened within the home and how to reduce the risk to people.

Staffing and recruitment
• Overall, we concluded there were enough staff deployed to ensure people received appropriate care. Staffing levels were based on people's dependencies. People told us there were enough staff. One person said, "I think there is enough staff, they come when I want them." Staff told us that staffing levels were usually sufficient and rotas we reviewed confirmed this. We observed communal areas were appropriately supervised with staff taking care to ensure they were always present to observe people in the lounges.
• Safe recruitment practices were in place to help ensure staff were of suitable character to work with vulnerable people. New staff received an induction to the service, shadowed existing staff and received a range of training. To improve the safety of the service, additional training had been arranged in key areas including falls prevention and skin integrity to improve the skills of staff.

Using medicines safely
• Some improvements were needed to medicine management systems to ensure medicines were managed in a safe and proper way. For example, people were at risk of being given doses of some of their medicines too close together or at the wrong times because the provider's systems did not include checks to make sure this did not happen. Written guidance was in place when people were prescribed medicines to be given "when required" but the guidance was not always personalised or detailed enough. Staff did not have access to enough information to assist in deciding when someone may need the medicine or how much to give.
• Information was missing from people's care records, which would have supported staff to give covert medicines safely. Waste medicines were not always stored correctly and the medicine room was cluttered when we visited the service.

We did not identify anybody was harmed, although there was the potential for this as safe and proper medicines management systems were not in place. This demonstrates a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The provider responded and took action to address the issues we identified.

• We identified some good practice. Creams were managed safely. Where people received topical medicines such as creams risk assessments were in place considering the risks associated with the flammable nature of the products. Stock checks and medicines records showed medicines had been given as prescribed and all could be accounted for. Staff had received training in medicines management and had their competency to give medicines assessed.

Learning lessons when things go wrong

• Lessons were learnt by the service when things went wrong. The management team had worked hard over the last few months to improve a number of systems, for example relating to safety checks, and action taken following accidents, incidents and medicine errors.

• Clear and detailed analysis took place of incidents and accidents on a monthly basis to identify any themes and trends. We saw the number of incidents and accidents had reduced over recent months.

• The management team were receptive to our feedback and made immediate improvements, for example to care plans and risk assessments where we identified gaps.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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

• Systems were in place to assess, monitor and improve the service however some of these needed to be made more robust. We saw some good examples of audits and checks effectively identifying issues and being used to improve the service. However, we identified some inconsistent practice with infection control practice and medicines management which constituted breaches of regulation. Systems should have been operated to ensure these areas performed to a consistent high standard. We were encouraged that the management team took immediate action to rectify the issues we identified and improve governance procedures.

• Staff we spoke with were clear about their roles and responsibilities. We found the service was open and transparent with us and fulfilled its statutory duty to report notifications such as incidents to us. These were investigated thoroughly in an open and transparent way.

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

• There was a positive and person-centred culture within the home. People and relatives praised the overall quality of the service and reported good outcomes. One person said, "I get fantastic attention and have everything I need. There's some lovely staff here. I'm very happy and well cared for." Relatives told us communication with the home was good and they had been kept up-dated during the COVID-19 pandemic.

• Staff told us they felt well supported by the service and able to approach the management team with any concerns or problems. We saw staff being kind and caring towards people and delivering compassionate care.

• Measures were taken by the service to ensure both people who used the service and staff were treated fairly and we concluded discrimination was not a feature of the service. People's individual needs and circumstances were taken into account when planning care and supporting staff.

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

• People and relatives provided good feedback about the service. We saw they were frequently engaged with. This included resident and relative meetings, surveys and care reviews. During the COVID-19 pandemic, people had been supported to keep in touch with relatives remotely. Relatives spoke of "good

communication" and "being kept in the loop."

Continuous learning and improving care;
• Systems were in place to ensure improvement of the service and continuous learning. Whilst there had been a number of concerns raised about the service over the last 12 months, we found the management team had responded positively to these, adapting and developing systems to help improve the quality of the service.
• Work was ongoing to improve various aspects of the service. This included a programme of refurbishment and a review of staff training needs. A number of new training topics had been provided to staff and the service was developing a subject champion role to have staff who actively promoted key subjects within the home.

Working in partnership with others
• The service had worked hard to develop good working relationships with others including the district nursing team, GPs and commissioners. We saw additional systems had been put in place to promote good communication between the service and others to reduce the risk of misunderstandings.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2g) (2h) Medicines were not consistently managed in a safe and proper way. The risk of infection was not always properly assessed and managed.