Mentaur Limited

# Highfield

## Inspection report

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Date of inspection visit:
23 January 2023
24 January 2023
25 January 2023

Date of publication:
07 March 2023

## 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 is a residential care home providing accommodation and personal care for up to 6 people with a learning disability, autistic people, people with mental health needs and people with sensory impairments. At the time of the inspection 6 people were living in the home.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found
Right Support:
Risk assessments and care plans relating to people's known health conditions were out of date and not reflective of people's current needs.
People did not always receive support that was focused on their quality of life outcomes. People's outcomes were not regularly monitored in a meaningful way.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the systems and processes in the service did not always support this practice. Medicines were managed safely.

Right Care:
People were supported by staff who knew them well and who had been safely recruited. However, not all staff had received the relevant training to ensure they had knowledge of people's health needs. The provider allocated new training to all staff immediately after feedback.

People, relatives and staff were given the opportunity to feedback on the service. However, there was no evidence to show how the feedback was used to drive improvements in the service

People received kind and compassionate care from staff who used positive, respectful language which people understood and responded well to.

Right Culture:
Governance processes were not effective and failed at times to hold staff to account, keep people safe, protect people's rights and provide good quality care and support.

There was mixed feedback from staff about whether they felt supported in their roles. Staff did not receive regular supervisions and the lack of consistent leadership at the service resulted in a decline in the quality

and safety of the service.

People and relatives were positive about the attitudes and behaviour of staff.

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 28 March 2018)

Why we inspected
This inspection was prompted by a review of the information we held about this service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

Enforcement and Recommendations
We have identified breaches in relation to management oversight and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## 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

**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 Health and Social Care Act 2008.

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 completed by 1 inspector.

Service and service type
Highfield is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Highfield is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A manager was registered, however they had not worked at the service for 15 months.

Notice of inspection
This inspection was unannounced.

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 who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who used the service and 2 relatives about their experience of the care provided. We spoke with 6 members of staff including the manager, quality and compliance manager and care workers.

We reviewed a range of records. This included 3 people's care records and multiple medication records. We looked at 3 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.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Staffing and recruitment

- People were at risk from known health conditions. Risk assessments and care plans relating to people's known health conditions were out of date and not reflective of people's current needs. Staff did not always follow the guidance in place to manage people's health conditions. Records of health events were not always accurate.
- When there was a change in health conditions, information was not shared in a timely manner to ensure the appropriate treatment, support and review of care plans was in place for people.
- People were not supported by staff who had the appropriate knowledge and skills to keep them safe. For example, staff had not received training in epilepsy or diabetes. This placed people living at the service with these health conditions at risk of receiving unsafe care.
- Records relating to risk had been reviewed, however, information remained inaccurate and this had the potential to place people at risk of harm.

The provider had failed to ensure staff had received the appropriate training and had their competence assessed to undertake their role safely. The provider had failed to ensure risks to people were safely managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The quality and compliance manager updated care plans and risk assessments immediately after inspection.

- Safe recruitment practices were in place and the provider used references and the Disclosure and Barring service (DBS). Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions
- We found sufficient staff were deployed to maintain people's safety and meet individual needs. People told us and we observed, staff were available to people when they needed them.

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

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Using medicines safely
● The provider had identified concerns with medicines management and had taken appropriate action to address these. Audits on medicines were completed and any errors were actioned.
● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles.
● When people required 'as required' (PRN) medicines the reasons for administration were recorded and staff had all the information required to administer them as prescribed.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe. One person told us they felt safe with the staff that supported them in their home. One relative told us they felt confident staff would care for their relative and inform them if they were unwell.
● Staff were knowledgeable in safeguarding people and understood the signs of abuse and how to raise concerns if they needed to inside and outside of the organisation. Staff had access to a whistle-blower policy to support them with raising concerns.
●The manager was fully aware of their responsibilities to raise safeguarding concerns with the local authority to protect people and had notified CQC appropriately of concerns.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● 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.

Visiting in care homes
● The provider followed government COVID-19 guidance on care home visiting.

Learning lessons when things go wrong
● Incidents and accidents were recorded, detailing who was involved and any injuries sustained. However, not all incident forms had been completed appropriately and action taken to address any health concerns after the incident had not been identified. We shared our concerns with the manager and the quality and

compliance manager. Following the inspection, the quality and compliance manager sent us information to confirm this was being addressed immediately.

● There was insufficient evidence at this inspection to confirm lessons were learned when things went wrong. We will review this at our next inspection.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Systems and processes to ensure records were kept up to date and factual was not always effective. We found details of people's health appointments were not consistently recorded, care plans and risk assessments held incorrect or had missing information within them and there were gaps in the recording of people's keyworker meetings.
- Systems and processes were not in place to ensure records of incidents and health appointments were accurately recorded. We found some incidents had not been recorded appropriately and health appointments had not been recorded.
- The service had an unstable management team for the previous 12 months and this was reflective in out of date records, knowledge of systems and processes and auditing the quality and safety of the service.
- The lack of consistency in the management team impacted the culture of the service. There was evidence of people not being supported to work towards achieving their goals and not being supported in a person-centred approach.
- The provider had identified shortfalls in the quality and safety of the service; however, this had failed to drive improvement.
- Best practice guidance for the use of personal protective equipment (PPE) had not been followed.
- Systems and processes to ensure staff had the skills, knowledge and training to meet people's needs was not effective. We found not all staff had training in epilepsy, diabetes, learning disabilities or autism.
- We received mixed feedback from staff on how supported they were in their role. Some staff felt unsupported and told us they had not been given the opportunity to learn the skills they felt were needed for the role. 1:1 supervision to discuss staff progress, support, knowledge gaps and training requirements was inconsistent. Some staff however, felt they were supported enough to complete their role safely.

The provider had failed to have robust systems and processes to assess, monitor and improve the service. This is a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they felt supported by the current manager and were confident they would address any concerns raised with them. One staff member told us, "[Manager] is approachable, I wouldn't hesitate to raise any concerns with them."

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 manager and provider understood the duty of candour. We saw they predominantly fulfilled their legal responsibilities. However, some relatives and staff told us that the management were not always open when things go wrong.

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

● People, staff and relatives felt involved with the service. However, weekly meetings for service users were not always consistent and poor records were kept of the meeting and did not accurately reflect the topics of discussion.

● Feedback was sought from people and those important to them. However, there was no action plans in place to show how the feedback was used to develop the service and drive improvement.

● There were visual structures in place, including photographs, use of gestures and symbols which helped people understand and communicate effectively.

Working in partnership with others; Continuous learning and improving care

● The service worked well in partnership with other health and social care organisations. Advice was sought when people's needs changed.

● The service liaised with healthcare professionals to coordinate better care for people.

● The manager was engaged and open to the inspection process and remained open and transparent throughout. Concerns found on inspection were responded to promptly.

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<br><br>The provider had failed to ensure risks to people were safely managed. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to have robust systems and processes to assess, monitor and improve the service. |