Rushcliffe Care Limited

Highfield Court

Inspection report

Stafford Road
Uttoxeter
Staffordshire
ST14 8QA

Tel: 01889568057
Website: www.rushcliffecare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

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.

About the service
Highfield Court is a residential care home providing personal care to 42 people who have learning disabilities and autistic people. Some people also have mental health needs. The service can support up to 59 people. The accommodation is divided into 22 separate bungalows. Some people live alone and others live in small groups. People have the option of having their meals at the on-site bistro, or in their own homes. There are several communal buildings and large gardens and outside space within the grounds people can access for recreation or activities.

People's experience of using this service and what we found
Right support
Highfield Court does not meet the current Right Support, Right Care, Right Culture guidance which says that residential care should usually be provided in small, local community-based units. However, people told us they spent time in their local communities. One person said, "There's a shop within walking distance, the closest town is Uttoxeter. I would get a taxi or staff take me." People also told us they benefited from the rural location.'

The provider had not always ensured people had maximum choice and control over their lives, as some people's capacity to make specific decisions had not been assessed and recorded. This meant staff may not always 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. However, staff knew people well and understood their histories and experiences.

People were supported to make decisions about their living arrangements and, where requested, people had been offered alternative accommodation on site. The COVID-19 pandemic had impacted on the way people chose to spend their time, but this had been recognised by the provider who had established on-site activities to support people's interests and well-being. Improvements had been made to ensure the model of care offered people more choice, control and independence.

Right care
People's medicines were not managed safely. Some aspects of people's care, including sexuality and spirituality, had not always been considered. Despite this people received support from staff who were kind and compassionate. End of life care planning had not always been recorded.

Staff understood people's communication styles and responded quickly where people were distressed or raised concerns. Staff had received training in how to protect people from harm and knew how to report any concerns for people's safety.

Right culture
Language used to describe people and their behaviours was not always respectful and did not always reflect a positive ethos. Audits used to monitor the quality of care people received were not always effective in identifying and driving the required improvements. People had been involved in reviews of their care and were given opportunities to be involved in developing the service through the resident's forum.

The provider had appointed two newly registered managers. They had developed an action plan to address the areas of concern identified at the previous inspection. People knew who the registered managers were and felt confident to approach them.

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 28 September 2021) and there were breaches of the regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found some improvements had been made, particularly in relation to person centred care, however the provider remained in breach of regulations.

The last rating for this service was requires improvement. The service remains rated requires improvement. This service has been rated requires improvement or inadequate for the last five consecutive inspections.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture and to follow up on action we told the provider to take at the last inspection.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

Prior to the inspection the provider notified us of a specific incident, following which a person using the service died. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of people with modified diets eating and drinking. This inspection examined those risks.

We found no evidence during this inspection that people were at risk of harm from this concern. Please see the Safe and Effective sections of this full report.

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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, the need for consent and good 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 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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive 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 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.

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
Two Inspectors, an assistant inspector, a member of the CQC medicines team and an Expert by Experience carried out the inspection. 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 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 two managers 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 reviewed information the provider had sent us about actions they had taken since the last inspection. We sought feedback from the local authority and health professionals who work with the service.

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

During the inspection
We spoke with eight people who used the service and eight relatives about their experience of the care provided. We spoke with eight members of staff including four care team leaders, three care workers and one member of the housekeeping team. We also spoke with the deputy manager and two registered managers. We spent time observing people and their interactions with staff.

We reviewed a range of records. This included six people's care records and 10 medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including audits and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records and further evidence submitted by the provider relating to the governance of the service.

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 requires improvement. At this inspection this key question has remained the same. 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.

Using medicines safely

At the last inspection we found people received their medicine as prescribed, but medicines audits had not identified all the issues the management team needed to address, specifically in relation to the storage of medicines. At this inspection wider concerns were identified, and we found people's medicines were not managed safely.

- Medicines were not administered safely. Staff did not follow the service's administration procedure or always sign the medication administration record (MAR) after observing a person take their medicine.
- One person was prescribed eye drops after treatment at the hospital. There was no MAR to show the drops were being administered at the right times.
- Medicines stored in the central office were kept at the right temperature and cupboards were clean and tidy. However, some people's medicines were kept in their bungalows and temperatures inside their medicine cabinets were not recorded. The cabinet in one bungalow contained medicines for two people and the medicines were not separated. This put one person at risk of harm from wrongly being given a medicine (prescribed for the other person) to which they were allergic.
- People's medicines to be taken when required to treat anxiety and agitation were not used excessively but were not reviewed regularly to see if people still needed them.

Medicines were not safely administered or 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. They took action to ensure people's medicines were safely stored. The provider also told us they had created a new role of 'medication supervisor' and appointed a newly recruited staff member to this role with immediate effect. They told us this would improve consistency in the administration and management of medicines. In the weeks following the inspection the two newly registered managers also undertook additional medicines training which they planned to share with the staff team.

Systems and processes to safeguard people from the risk of abuse

At the last inspection we found the necessary safeguards to protect people were not always in place. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was no longer in breach of this regulation.

● People told us they felt safe living at Highfield Court. One person said, "I feel safe here, if I have a problem, I tell the staff and it gets sorted." Relatives were also confident people were safe, one commented, "[Person's name] is safe and happy there."
● Staff had received training in how to keep people safe and protect them from harm. Staff we spoke with knew how to escalate any concerns for people's safety or well-being. One staff member said, "I did the safeguarding training, if I saw any signs of abuse, I would report it to the manager or the safeguarding team, there is a number in the office."
● We reviewed records relating to incidents and events and found the provider had taken appropriate action where people were at risk. They had reported concerns to the local safeguarding team and CQC as required.

Assessing risk, safety monitoring and management
● Risks, including those in relation to epilepsy, skin integrity and mobility were managed and staff understood how to support people safely.
● Where people used expressive behaviours as part of their communication, staff were given guidance in care plans and risk assessments about how best to support people. Staff told us they had received training to ensure they supported people in the least restrictive way possible. One staff member said, "I work with [person's name] and they have a care plan on how to manage situations. I know them very well."
● People's changing risks were shared with the staff team so they were able to meet people's current needs safely. For example, where people had received support from a speech and language therapist in relation to safe swallowing, we saw care plans had been updated and information shared with staff.

Staffing and recruitment
● People told us and we observed there were enough staff to meet people's needs and respond when people needed them. Staff we spoke with felt there were enough staff throughout the day and night-time to support people well. One staff member said, "The staffing levels are okay, we get to meet everyone's needs. We get time to read care plans and relevant information about residents."
● Staff had been safely recruited. The provider had carried out appropriate pre employment checks on staff to ensure they were safe to work with people.

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 meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were somewhat assured that the provider was using PPE effectively and safely. This was because we observed some staff were either not wearing their PPE appropriately or not wearing it at all. We shared our observations with the registered managers who took action to address our concerns.

● We were assured that the provider was accessing testing for people using the service and staff.

● 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.

Learning lessons when things go wrong
● Staff understood their responsibility to report incidents and accidents. Information recorded by staff was reviewed by the registered managers to identify any patterns or trends and reduce the risk of reoccurrence.
● Where incidents had occurred, there was evidence learning had taken place with both the staff and management team. For example, following a serious incident we found processes for sharing information with the staff team about people's health needs had been improved.

Visiting in care homes
● The registered managers had limited the number of visitors on site following advice from the local public health team, because staff members had recently tested positive for COVID-19 and they wanted to minimise the spread of infection. The registered managers understood the current visiting guidance and had plans in place to welcome visitors again when it was safe to do so.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

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 did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

At the last inspection we removed a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Although we removed the breach, we noted further work was required in the area of ensuring people's consent and decision making had been appropriately assessed and recorded. At this inspection we found further improvements were still required and the provider was in breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

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.

- We found assessments of people's capacity had not been consistently completed for people where they lacked capacity to make specific decisions.
- Where restrictions were identified for one person, a DoLS application had been made, however there was no documented associated MCA assessment for that individual.

The provider had failed to ensure that where a person lacks mental capacity to make an informed decision, or give consent, staff had acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered managers told us and records confirmed, they were aware of the concerns we identified in relation to decision making. The deputy manager had begun meeting with people to assess their capacity to make some specific decisions and this process was on-going at the time of the inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Most of people's needs had been assessed to ensure their care and support met their needs. However, we found people's needs in relation to sexuality, religion or spirituality had not always been assessed or recorded. This meant people may not receive support in areas essential to their identity or well-being.
● We shared these concerns with the registered managers who, following the inspection, shared with us a care plan for one person which included guidance for staff about how to meet their sexuality needs. However, further improvements were required to ensure staff were aware of how to support people with all aspects of their care and support.

Supporting people to eat and drink enough to maintain a balanced diet
● At the last inspection we found people were not always given a choice about where they would like to eat. At this inspection, improvements had been made and people made their own choice about whether to eat in their own home or the on-site bistro.
● People told us they were happy with their mealtime choices. One person said, "I am going to the bistro for meals, the food is very good. There is a good choice of meals and we had a meeting and we discussed suggestions about what could be on the menu."
● Where people required support with eating and drinking, health professionals had assessed their risks and offered guidance to staff about how to safely support people. Two assessments had taken place on the day prior to the inspection and we found the information had been shared with staff so they were aware of any changes to people's care and support.

Staff support: induction, training, skills and experience
● People told us they felt staff knew them well and were supported by the management team. One person said, "Staff are respectful, kind and polite. [Name of registered manager] and [name of deputy manager] give clear guidance and direction to staff."
● Staff told us they received an induction and training and felt equipped to meet people's needs. One staff member commented, "I shadowed shifts and had time to read care plans and risk assessments. I did lots of training too, I felt confident and well supported."
● We observed staff interacting with people and saw staff knew people well, understood their anxieties and were responsive when people approached them or asked for assistance.

Adapting service, design, decoration to meet people's needs
● People lived in bungalows across the site and accessed communal spaces for activities and learning opportunities. On the days of the inspection people were unable to leave the site, or access some of the communal buildings, due to a COVID-19 outbreak. However, people told us they usually benefited from the activities that were available.
● People's bungalows were personalised and adapted for their needs. We saw adaptations in people's kitchens and bathrooms supported them to live as independently as possible.
● People used the gardens and outdoor shelters to spend time safely with others. Limited numbers of people also used the communal indoor spaces to take part in recreational activities led by staff.

Supporting people to live healthier lives, access healthcare services and support
● People told us they received support with their health needs. People told us and records confirmed they had accessed services such as the optician, GP and hospital when required.

● At the last inspection we identified concerns about the quality of documentation about how people's health needs would be met. At this inspection we found improvements had been made. People had been involved in discussions about their health and plans were in place giving consideration to people's future health needs.

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 not reviewed. However, when last reviewed in 2019 we rated this key question 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

- Daily notes about people's care were not always respectful in terms of the language used to describe people or their behaviour. Further training was required to ensure staff recorded the support they provided in a positive and caring way.
- We discussed our concerns about recordings with the registered managers who told us they had already identified this as an area for improvement. Care plan reviews were underway at the time of the inspection and following the inspection work was undertaken with staff including observations of practice and further guidance issued about using person centred language.
- Despite these concerns people told us they felt staff treated them with kindness. One person told us, "The staff are alright, they know me and know what I like. They know about my history and past experiences." Another person said, "The staff are very caring."

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

- People told us they were supported by staff to make decisions about their care and support. One person said, "The staff are pretty good, they do listen and respond."
- Care plans included information for staff about people's preferences and how best to support them to make choices.
- Where people lacked capacity to make specific decisions, assessments were required to ensure staff were acting in their best interests. The registered managers were aware of these concerns and the deputy manager had been tasked with meeting with people to assess their capacity for certain decisions.

Respecting and promoting people's privacy, dignity and independence

- We observed positive interactions between people and staff. People appeared comfortable around staff and we saw staff members gently encouraging people to make changes to their clothing where their dignity was compromised.
- Staff demonstrated a good awareness of how to support people sensitively and in a dignified way. One staff member told us, "I knock on doors, keep doors closed and curtains too. We use dignity towels during personal care. We encourage residents to do as much as they can for themselves but respect their choices. We use people's preferred names."

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 remained the same. This meant people's needs were not always met.

At the last inspection we identified people were not consistently being supported in accordance with Right Support, Right Care, Right Culture. The model of care did not allow people to develop or maintain their independent living skills. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At this inspection we found improvements had been made and the provider was no longer in breach of this regulation. However, some improvements were still required.

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

- Care plans did not consistently reflect people's preferences, particularly in relation to their diverse needs under the Equality Act 2010. For example, information about people's spiritual or religious preferences had not been considered and there was no guidance for staff to follow about how best to support people in this area.
- People were involved in planning their care and improvements had been made since the last inspection in relation to the opportunities for independent living. Some of the people we spoke with told us they took responsibility for cleaning their own properties and others received support from staff.
- Records reflected people's involvement in planning their care and people had been asked to consider what was important to them in their day to day lives, as well as any future aspirations. Care plans also reflected how staff should best support each person in accordance with their likes and dislikes.

End of life care and support

- End of life care planning and future wishes had not always been recorded. Although there was no one in receipt of end of life care at the time of the inspection and the registered managers recognised a need to have these conversations with people, this had not yet been done.
- Following the inspection, the provider sent us evidence that some people's funeral plans had been discussed.

Improving care quality in response to complaints or concerns

- We observed people raise concerns with staff and the registered manager and they responded to address these straight away. However, we found these concerns were not always be documented as there had been no recorded complaints since last inspection. Following the inspection, the registered manager advised an informal complaints log had been established to ensure all complaints were recorded and reviewed.
- Information about how complaints could be made to the provider was on display in a suitable format in the office reception area. There was a system established to manage complaints.

● People told us they felt confident to raise concerns and that staff and the management team responded to them. One person said, "The manager is alright, I see her most days, she knows me, I can talk to her when I need to."

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

● We received positive feedback from people and some relatives about the opportunities available for activities and learning. One relative told us, "[Person's name] loves going to the lodge, they do keep fit, singalongs, outside singers come in, they do loads of craft. There are a lot of horticultural activities and use the produce in the kitchen. We can see it all on Facebook."

● Although the option of people spending time away from Highfield Court was limited at the time of the inspection due to Covid-19 restrictions, staff were available to offer activities and meaningful occupation.

● People told us they accessed the hub, which was an on-site resource centre. The resident's forum was held monthly, and people were involved in compiling a monthly newsletter reflecting life at Highfield Court, which could be shared with friends and relatives. Some people had discussed plans to attend college courses, while others worked as volunteers locally.

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.

● People's individual communication needs had been assessed and planned for. Information and guidance for staff on people's communication needs was included in people's care plans.

● There was information available which indicated the provider understood the accessible information standards.

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 requires improvement. At this inspection this key question has remained the same. 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.

At the last inspection we found although there had been some improvements in this key the provider was still in breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. At this inspection we found there had been further improvement, however the provider was still in breach of the regulation. This is the sixth time the provider has been in breach of this regulation.

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

- Since the last inspection, the previous registered manager and the deputy manager had left the service. Two newly appointed registered managers had been appointed, both were established staff members who understood the needs of people living at the service. Since becoming registered they had worked together to identify the areas that required improvement. They had developed an action plan to help them address each area and so they could monitor actions taken and completed.
- The action plans the registered managers were working towards had identified most of the areas of concerns we found during the inspection. In most, but not all cases, the management team, with the support of staff were working towards the required improvements.
- However, in some cases audits had not been effective in recognising or addressing all areas of concern. For example, medicines audits had not identified the risks associated with medicines storage and a lack of reviews. A recent medicines audit had noted staff were failing to sign MAR sheets when administering medicines, however we observed this was still happening during the inspection. IPC risks had been identified in recent audits; however, we saw staff not wearing PPE on the day of the inspection.

The provider had failed to establish systems to effectively assess, monitor and improve the quality and safety of the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

- The rating from the previous inspection was displayed prominently within the reception area as required by law.

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

- Improvements made at the service meant that people were now receiving care that was more

personalised to them and promoted positive outcomes. However, further improvements were still required in relation to people's individual diverse needs. The service was still not able to fully demonstrate they were meeting the principles of Right Support, Right Care, Right Culture, which reflects the key elements people with a learning disability should get from their service.

● People spoke positively about the staff and management team and some people told us they felt there had been improvements made which had a positive impact on them. One person said, "I think the staff team has got better and the management team, I can't really explain why, maybe they listen more."

● Staff spoke positively about the culture of the service. One staff member said, "I enjoy my job, it's a good place to work, it is a good atmosphere, I like working with the people."

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 managers were aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation which all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.

● Where things had gone wrong the management team had worked alongside other agencies to learn from events. They had also spoken with families to understand concerns and explain any changes or improvements that would be made as a result of the learning that had taken place.

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

● People were involved in the development of the service through a resident's forum. This group offered feedback to the provider about what life was like at Highfield Court and made suggestions about how things could be improved.

● Care plans had been reviewed and reflected people's feedback on the care and support they received.

● Staff told us they felt able to raise any concerns or suggestions for improvements with the management team. One staff member said, "[Name of registered manager] is very approachable; they listen to suggestions.

Continuous learning and improving care; Working in partnership with others

● Improvements had been made since the last inspection. The management team had worked with the staff team to ensure people were receiving personalised care which met their individual needs and gave them positive outcomes.

● The registered managers were open to the feedback we provided during the inspection and acknowledged where improvements were required. Following the inspection they continued to work to improve the areas of concern and submitted further evidence to us demonstrating the actions they had taken.

● The staff team and registered managers worked in partnership with other agencies to ensure people's care and support needs were met. Where appropriate, people's relatives had been involved in reviews of their care, as well as healthcare professionals and social workers.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that where a person lacks mental capacity to make an informed decision, or give consent, staff had acted in accordance with the requirements of the Mental Capacity Act 2055 and associated code of practice. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not safely administered or managed. This placed people at risk of harm. This was a breach of regulation 12 (2.g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 establish systems to effectively assess, monitor and improve the quality and safety of the service. This was a continued breach of regulation 17 (2.a) of the Health and Social Care Act 2088

(Regulated activities) Regulations 2014.