Highcliffe House Limited

Highcliffe House Nursing Home

Inspection report

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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

We undertook an unannounced focused inspection of Highcliffe House Nursing Home on 14 January 2019. This inspection was done to check that improvements to meet legal requirements planned by the provider had been made after our comprehensive inspection on 25 April 2018. The team inspected the service against two of the five questions we ask about services: is the service well led and is the service safe? This is because the service was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining key questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection.

The inspection took place on 14 January 2019 and was unannounced. During our last inspection on 25 April 2018 we found breaches to Regulations 17 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that improvements had been made. There was still improvement needed, which was underway and the service was no longer in breach of regulation.

Following our last inspection in April 2018, the overall rating for this service was 'Inadequate' and the service was put in 'special measures'. The service was kept under review and was inspected again within six months. Because, during this inspection we found the service had made sufficient improvement to be rated requires improvement, this service is no longer in special measures.

Highcliffe House Nursing Home is a 30-bedded residential and nursing care service providing care, treatment and support, including end of life and care and support for people living with dementia. On the day of our inspection there were 19 people living at the service.

At the time of our previous inspection in April 2018, the registered manager was also a director of the registered provider. Soon after that inspection the registered manager stepped down and a new manager had been appointed who had started the process of becoming registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Highcliffe House a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 accommodates people in one adapted building close to the sea in Felixstowe.

During our last inspection in April 2018, we found that not all internal doors that had signage to say, 'keep locked shut' for people's safety were kept locked. During this inspection we found that these doors were

locked, keeping materials that could be harmful to people safe and steps had also been taken to ensure that access to the cellar was monitored when staff were in the kitchen to ensure people were safe from falling down the stairs, but this gate needs to be kept locked at all times.

Improvements had been made in the quality of people's care plans and the way that risks were identified and measures put in place to help protect people from harm. But the standard was not consistent throughout people's care plans and we found that a piece of equipment mentioned in a risk assessment that was essential for the person's safety was not in working order. This was rectified immediately.

People where protected from bullying, harassment, avoidable harm and abuse by staff that were trained to recognise abusive situations and knew how to report any incidents they witness or suspected. Improvements had been made since our previous inspection and appropriate safeguarding referrals had been made.

People were protected by staff that had been safely recruited.

Medicines were managed in a way that ensured that people received them safely and at the right time. There were also appropriate infection control practices in place to help protect people, visitors and staff from infectious disease.

Staffing levels were sufficient to keep people safe on the day of our inspection. We saw evidence that lessons were learnt and improvements made when things went wrong.

The way the service was managed had improved since our last inspection and the provider and manager had made a positive move towards improving the service. There were systems in place to monitor the quality of service the providers offered people, however there were still some inconsistency in records and in identifying the concerns including those we identified during this inspection.

Improvements had been made in the culture of the service. Staff told us that things had improved and the service was a better, happier place to work in. People and staff told us the manager was open, supportive and had a good, caring attitude in the way they believed people and staff should be supported.

The service had worked in partnership with other agencies whilst working to make improvements to the quality of care offered to the people they support.

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.

Systems in place to assess and respond to risk were not consistent.
People were protected from bullying, harassment, avoidable harm and abuse.

Staffing levels were sufficient to keep people safe. Medicines were managed in a way that ensured that people received them safely and at the right time. There were appropriate infection control practices in place to help protect people from infectious disease.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were systems in place to monitor the quality of service the providers offered people, however there were still some inconsistency in records and in identifying the concerns including those we identified during this inspection.

The service had worked in partnership with other agencies whilst working to make improvements to the quality of care offered to the people they support.

Highcliffe House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 January 2019 and was unannounced. The inspection team consisted of two inspectors, a specialist professional advisor in nursing care for older people 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. On this occasion our expert had experience of caring for a family member who was living with dementia in a care home.

Before the inspection we reviewed information available to us about this service. The registered provider had completed a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help inform our inspection. We also spoke with stakeholders, including the local authority safeguarding team.

We reviewed the provider's updated action plan as well as previous inspection reports, the details of any safeguarding events and statutory notifications sent by the provider. A notification is information about important events which the provider is required to tell us about by law, like a death or a serious injury. We used this information to plan what areas we were going to focus on during our inspection.

We spoke with eight people who could express their views of the service they received. We also observed care to help us understand the experiences of those people who were unable to communicate effectively with us.

We also spoke with three relatives of people living at the service, five members of staff, a nurse and the clinical lead. We reviewed seven people's care plans. We also looked at a sample of the service's quality assurance systems, staff training records, staff duty rotas and complaints records.

Requires Improvement

Is the service safe?

Our findings

We have inspected this key question to follow up the concerns found during our previous inspection on 25 April 2018. During that inspection we rated this key question inadequate and found that the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that the service had made sufficient improvements for this key question to no longer be rated inadequate and were no longer in breach of regulation. However, there are some areas that needed further improvement and we have rated this key question as requires improvement.

During our last inspection in April 2018, we found that not all internal doors that had signage to say, 'keep locked shut' for people's safety were kept locked. During this inspection we found that all these doors were locked, keeping materials that could be harmful to people safe.

Not all risks to people had been fully addressed. During the inspection in April 2018, we found that the approach to health and safety matters was inconsistent. Although issues raised at the inspection prior to April 2018 had been addressed, we found other examples of poor health and safety matters.

During this inspection we found that health and safety audits were carried out and were mainly effective. However, we identified areas where improvement was needed. A gate had been put across the steep, concrete stairs to prevent access to the cellar. Kitchen staff told us that they were aware of the danger to people if they gained access to the stairway and asked people to leave if anyone approached the area. However, when there were no staff in the kitchen, people had access to the area. The gate must be locked to ensure people's safety.

Care plans had been updated and formatted in a way that were easier to access information than they were at our previous inspection in April 2018. However, the way risks were recorded and managed was inconsistent and we continued to find risks that were not being properly managed. For example, one person's nutritional plan referred to them having a 'normal diet' but this had not been updated after the person had three incidents of choking to reflect that identified risk. The care plans had not been updated to reflect the new risks.

The person had not immediately been referred to the speech and language team (SALT) for an assessment and guidance to help reduce the risks of the person choking. The SALT team asked for incident charts to be kept that would help in the person's assessment. There were no incident charts in place that would help to establish triggers, and explain what action had been taken to support the person.

One person's choking risk assessment stated that a suction machine should be used if the obstruction could not be immediately cleared. But we found that the suction machine was not ready for use, in fact it was not useable when we first examined it. The manager had taken immediate action and it was working later in the day. They also added further steps to the risk assessments and audit checks to help avoid similar risks to people being overlooked in the future.

People told us that they felt safe living in the service. One person said, "I feel safe here and I think staff have done a good job. I am particularly pleased about how well my legs have been looked after."

People were protected from bullying, harassment, avoidable harm and abuse by staff that were trained to recognise abusive situations and knew how to report any incidents they witnessed or suspected. Records indicated that improvements had been made in this area since our previous inspection and appropriate safeguarding referrals were made and the service worked with the local authority safeguarding team during any investigation.

Staffing levels were sufficient to keep people safe on the day of our inspection. But the feedback from people and their relatives was mixed. Some people told us that they thought there were enough staff on duty. One person said, "I have my call bell and staff are pretty good, because I don't have to wait long. I understand that there are other people to care for." Other people felt there were not always enough staff on duty, which meant they sometimes had to wait for help. These thoughts were also reflected in the resident and relatives meeting notes and in comments made by some staff after the inspection visit.

We discussed these comments with the manager who told us about their expected staffing levels, which were reflected in the past, present and future rotas we looked at. We were also shown how the manager calculated people's dependency needs, which helped them calculate necessary staffing numbers. They explained that, as the number of people staying at the service increased, so would the staffing levels. They also said that if people's dependency levels changed, due to deteriorating health for example, staffing would be increased. The manager agreed to reassess people's needs and to make any necessary changes to ensure there were sufficient staff.

We saw that there was a policy and procedure in place for the safe recruitment of staff. The files showed that this procedure had been followed including disclosure and barring service (DBS) checks on staff and the attainment of references. This meant that the service continued to check staff's good character and suitability to work with the people who used the service.

People received their medicines as prescribed from staff who had received training in the administration of medicines. Medicines were stored appropriately in locked cabinets. We saw that details of people's medicines were recorded and all administrations had been signed by staff. We also saw protocols for people who had been prescribed PRN (as needed) medicines which contained information on when the person would need the medicine. We noted that each person's care plan also provided staff with guidance on how the person preferred to take their medicines and of any special measures that were in place for taking their medicines. For example, ensuring that people's blood pressure was taken before the administration of some medicines, where necessary.

The service was clean and hygienic. Staff were trained in infection control and food hygiene, those we spoke with understood their roles and responsibilities in relation to infection control and hygiene. There were systems in place to reduce the risks of cross infection. Liquid soap, hand sanitiser and disposable paper towels were available for people to use. There were gloves and aprons for staff to use to help limit the risks of cross contamination.

Action taken since our last inspection in April 2018 and quality assurance audits that had been put in place evidenced that the service had made improvements and learnt lessons when things went wrong. The manager had developed new policies and procedures and held debriefing sessions with staff following any serious events that occurred in the service. A policy of the week had been introduced where all staff had to read and sign they had understood the policy.

The manager had developed their understanding of their responsibilities in relation to raising concerns, recording and investigating safety incidents and reporting concerns to the local authority and other professionals. They provided an example of an investigation they had undertaken, in response to medicines errors and how this had been shared with staff, the people involved, their relatives and stakeholders. This related to medicines error brought to their attention. A management of medicines error form had been completed, which included a reflective analysis of the error. This document showed that the manager carried out a full and detailed investigation to establish what happened, who was involved and the consequences.

Requires Improvement

Is the service well-led?

Our findings

We have inspected this key question to follow up the concerns found during our previous inspection on 25 April 2018. During that inspection we rated this key question inadequate and found that the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that the service had made sufficient improvements for this key question to no longer be rated inadequate and were no longer in breach of regulation. However, there were some areas that needed further improvement and we have rated this key question as requires improvement.

The way the service was managed had improved since our last inspection and they had made a positive move towards improving the quality of the service people received. There were systems in place to monitor the quality of service the providers offered people, however there were still some inconsistency in records and in identifying concerns, including those we identified during this inspection.

The service has made progress with their development plan following our last inspection in April 2018. They prioritised areas they felt most important to deal with and dealt with safeguarding shortfalls first. The manager had redeveloped the development plan to reflect the way that the Care Quality Commission inspected services.

Whilst improved quality assurance systems had been implemented, these were in early stages. Although our last inspection was carried out in April 2018, monitoring systems had only just been implemented.

During our previous inspection in April 2018 evidence showed that there was a 'bullying and blame culture' within the service. During this inspection the manager told us that they believed their biggest achievement was changing the culture in the service. They said they had tried to develop a more open culture and had dealt with staffing issues that were impacting on the service. People and staff told us, and records showed, that the manager was open, supportive and had a good, caring attitude in the way they believed people and staff should be supported. Staff told us that things had improved and the service was a better, happier place to work in now.

Previous inspections had identified inconsistency in processes to investigate incidents where people had sustained injuries, such as unidentified bruising. This placed people's safety, health and wellbeing at risk. This inspection found significant improvement in the management of incident and accident reports. These were more detailed, unidentified bruising was being investigated and reported to safeguarding. A checklist was added to incident reports which identified all actions taken, including the date referred to the safeguarding team and the action they took.

The service held resident and relative's meetings where people were asked their opinion of how the service was run and what improvements were needed to improve their quality of care. The service had worked in partnership with other agencies whilst working to make improvements to the quality of care offered to the people they supported.