Care Quality Commission

Bupa Care Homes (CFChomes) Limited

Highfield Residential Home

Inspection report

London Road
Halesworth
Suffolk
IP19 8LP

Date of inspection visit: 16th and 23rd October 2015
Date of publication: 05/02/2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Highfield Residential Home is a care home providing care and support to a maximum of 40 older people, some of whom were living with dementia. At the time of our visit there were 37 people using the service.

The inspection was unannounced and took place over two days, on 16th and 23rd October 2015.

The home had a registered manager in place. 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 requirements in the Health and Social Care Act 2008 and associated regulations about the service is run.

Prior to the inspection, we had been made aware of an incident at the service which resulted in a person being injured. Once work around the circumstances leading to this injury are complete, this will be reported.

Summary of findings

People told us they felt safe living in the service. However, people were put at risk of harm because care records and assessments did not clearly reflect all current areas of risk and how these should be managed to protect the person from harm.

People told us they received their medicines when they needed them. However, we found that medicines were not managed and administered in a way which ensured people's safety.

This was a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not complying with the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). One person was being deprived of their liberty and right to consent unlawfully.

This was a breach of Regulation 11: Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not consistently supported to live full and active lives, and to engage in meaningful activity within the service. Some people told us of wishes they had expressed but that had not been fulfilled by staff, and we observed that people who chose to stay in their personal rooms did not have access to appropriate stimulation during our inspection.

Care planning for people was generic and not person centred. There were limited life histories for some people living with dementia. Some care records were not personalised to include people's hobbies, interests, likes and dislikes.

Improvements were required with regard to how people are involved in the planning of their support in the future, and how their views are reflected in their care records.

This was a breach of Regulation 9: Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a robust recruitment procedure in place to ensure that prospective staff members had the skills, qualifications and background to support people.

People told us, and we observed, that there were enough staff available to meet people's physical and emotional needs.

Staff received appropriate training, supervision and appraisal to carry out their role effectively.

There was a complaints procedure in and people told us they knew how to complain.

There were systems in use to monitor the quality of the service. However, these were not always effective in identifying shortfalls and areas for improvement. Prompt action was not always taken where issues which put people's safety at risk were identified.

This was a breach of Regulation 17: Good Governance of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

There was an open culture at the service and people were involved in discussions about their home. There was a process in place to gain the feedback or views of staff, and staff were included in the development of the service. People and their relatives were supported to give feedback on the service during surveys, and this information was used to improve the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

All of the risks to people were not clearly planned for and actions put into place to minimise the risks.

Medicines were not administered safely by staff.

Appropriate checks were carried out on new staff before they began work.

Is the service effective?

Requires improvement

The service was not consistently effective.

The service was not complying with legislation around the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

People had a choice of food and drink that met their needs, and were supported to maintain good nutrition.

Staff received appropriate training, supervision and appraisal for the role.

Is the service caring?

Requires improvement

The service was caring.

Staff interacted with people in a kind and caring way.

Positive relationships were formed between staff and people using the service.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People did not always have access to appropriate stimulation and activity.

Improvements are required with regard to the involvement people or their representatives have in the planning of care.

Improvements are required to ensure that people's care records are person centred, and reflect their preferences.

People had the opportunity to feedback their views and knew how to complain about the service.

Is the service well-led?

Inadequate

The service was not consistently well-led.

A quality assurance system was in place; however this did not always identify shortfalls.

Prompt action was not always taken where areas of risk were identified by the quality assurance system.

Summary of findings

The culture in the service was open, honest and positive.

Highfield Residential 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 over two days on 16th and 23rd October 2015 and was unannounced. The inspection was undertaken by four inspectors.

The provider completed a provider information return (PIR). This is a form that asks the provider to give key information about the service, for example, what the service does well and any improvements they intend to make. Before the inspection we examined previous inspection records and notifications we had received. A notification is information about important events which the service is required to tell us about by law.

We spoke with eight people who used the service, three members of staff and the deputy manager. We looked at the care records for seven people, including their care plans and risk assessments. We looked at staff recruitment files, medicine administration records, minutes of meetings and documents relating to the quality monitoring of the service.

Inadequate

Is the service safe?

Our findings

People were put at risk of harm because some risks had not been appropriately planned for and actions taken to minimise the risk. Several people using the service had fallen in the months prior to our inspection. Those who had fallen, or who had been identified as at high risk of falls, had no clear care plans in place to guide staff on what measures should be taken to reduce the risk. The service had not monitored falls to identify possible trends. For example, incident records showed that one person had been found on the floor of their room in the same place two nights in a row. However, the service had not investigated the circumstances behind these falls and why the person may have been getting out of bed. The service had not obtained the advice or input of external professionals such as the falls prevention team, who could have supported them to look at ways in which falls within the home could be reduced. For example We observed one person struggling to walk down the hallway, and attempting to grab hold of the wall to steady themselves. There were no handrails in communal hallways for people to hold on to if needed. This person was put at risk because the service had not considered ways in which the home could be made safer for people with reduced mobility or support them to be more independent

We found that medicines were not being managed or administered safely. For two people taking the same high risk medicine, we found that their medicines had been signed for on the medicine administration record (MAR) but remained in the box. The deputy manager investigated this, and stated that the tablets on these two separate occasions had been mistakenly taken from another person's supply of medicines. This put people at significant risk of receiving medicines not prescribed for them.

This was a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2010 (Regulated activities) Regulations 2014.

For people receiving 'as and when' medicines (PRN), there were clear protocols in place to guide staff on when it would be appropriate to administer the medicine and for what purpose it should be administered. One person told us, "I can have some pain relief whenever I want."

People told us they felt safe living in the service. One said, "I have honestly never felt threatened." Another person told us, "I do feel safe." A relative of one person said, "Absolutely, no concerns, [relative] is safe and well here."

People told us there were enough staff to meet their needs and keep them safe. One person said "Just say the word and they are there." Another said, "I think there are enough staff, yes. They are very attentive and I want for nothing." Another person told us, "Staff, there are plenty." A relative commented, "There always seems enough staff, I can always find one when I need one." Staff told us there were enough staff available to meet people's needs. One said, "Sometimes a bit short if someone doesn't turn up but normally all OK." Another said, "98% of the time there are enough and we do fine."

There was a robust recruitment procedure in place. Appropriate checks were carried out on prospective staff to ensure that they were suitable to work with people made vulnerable by their circumstances. These checks included ensuring that staff were not barred from working with the people using the service, and that they did not have any relevant criminal convictions that would make them unsuitable.

Staff had a good knowledge of safeguarding processes and procedures. They understood how to recognise abuse and what action they would be expected to take.

Safeguarding investigations were undertaken where concerns were raised either internally or by external agencies such as the Local Authority. These investigations were thorough, questioning and had clear outcomes which ensured people's safety and welfare in the future.

There were clear plans in place to protect people from harm in the event of an emergency such as a fire. Staff were able to tell us about these plans and how they would implement them to keep people safe.

Requires improvement

Is the service effective?

Our findings

People were put at risk of having their rights and liberties restricted unlawfully because the service was not following legislation around the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). People told us that staff did not always ask for their consent before carrying out care. One said, "I couldn't say they always ask because they don't. Some of them do, some of them just do whatever they think." Another said, "The cleaners the worst. They just come into my room in the morning and start tidying all my things up without asking." Another commented, "They have their jobs to do whether I agree or not. I don't feel like I can say no." A relative said, "They [staff] do what they need to do with or without my [relatives] agreement."

A staff member explained that one person refused to have personal care on a daily basis, and screamed, shouted and hit out at staff during this time. We reviewed the care records for this person and found that they did not have an appropriate DoLS authorisation in place which would allow staff to deliver personal care in their best interests against their will and without their consent. A formal best interest's process had not been completed in conjunction with other professionals to consider whether carrying out personal care against the persons will was in their best interests. A generic mental capacity assessment had been carried out for this person, but this was not decision specific. The person's capacity to refuse their personal care had not been assessed. There was no detailed care plan in place to guide staff on how they should support the person when they displayed behaviour that challenged, and the service had not considered the reasons behind these responses.

In all the care plans we reviewed, there was a generic mental capacity assessment in place for each person, including those who had capacity to make their own decisions. In addition, each person had a 'best interests' care plan, which stated what care they should receive in their best interests. The service had not followed a formal multi-disciplinary process when writing these care plans and had not consulted people, their relatives or other representatives.

This was a breach of Regulation 11: Need for consent of the Health and Social Care Act 2010 (regulated activities) Regulations 2014.

People told us they could choose what they wanted to eat and drink. One said, "There's a good choice, always lots on offer." Another commented, "Whatever I want I can have." One other person told us, "There is a menu, lots of choice on it." We viewed the menus and found that they showed pictures of the meals on offer, which may help people living with dementia make meal choices.

We observed the lunch time meal and saw that people were offered the support they required to eat their meals. People were provided with support discreetly, and staff asked each person if they needed any help cutting up their food. People who required full support with their meals were supported in a way which upheld their dignity.

The service had identified where people were losing weight, and appropriate assessments were carried out and care plans put in place to minimise the risk of malnutrition. Appropriate referrals had been made to other health professionals such as dieticians.

People told us that they could access support from other healthcare professionals when needed, and that the service supported them with this. One said, "The doctor comes to see us every Friday." Another person said, "I only have to ask." During one of our visits, a healthcare professional was visiting the service. They told us that the service worked well with them and was prompt in making referrals when a person became unwell.

Staff had appropriate training to ensure that they could deliver effective care to people. A relative of one person told us, "The staff appear skilled to my untrained eye." A person using the service said, "I'm confident they know what they are doing." Staff received regular one to one supervision with their manager, and these sessions were used as an opportunity to discuss the development of the service, staff knowledge and any issues in performance. Staff also received a yearly appraisal, where goals for development were set for the year and staff had the opportunity to request extra training opportunities they could benefit from, such as training in nutrition. One staff member said, "We are really well supported and very lucky we can always get extra training." Another said, "[Managers] are really lovely and couldn't be better. We get lots of help to better ourselves."

Requires improvement

Is the service caring?

Our findings

People told us that the staff were kind, caring and compassionate. One person said, "[Staff] are understanding and patient. Very kind." Another told us, "I feel like they care very deeply." A relative commented, "[Staff] have a caring attitude above all else, my [relative] says they always treat her very nicely."

We observed that staff treated people with kindness and compassion. For example, we saw one person become distressed. A staff member responded quickly to their need for reassurance, hugging them and speaking to them softly. We saw that this caring intervention eased the person's distress and shortly after they were smiling and laughing with the staff member. When we spoke with staff about people, they spoke about them in an affectionate manner, and demonstrated knowledge of people on a personal level.

People told us they felt listened to by staff and the managers. One said, "They listen to what I say even if they don't always like it." Another told us, "When I'm down they are always there to listen to me." A relative commented, "[Staff] listen to what we say and take it on board. They're very good."

People told us staff supported them to remain as independent as possible. One said, "They don't fuss around me which I like. They let me have a go first." A relative said, "They try and encourage [relative] to try themselves first. They've got [relative] walking again independently which is a real achievement."

People told us, and we observed that staff respected people's privacy and upheld their dignity. One person said, "I feel dignified." We observed that support with personal care or tasks such as supporting people to the toilet were carried out discreetly and privately. This upheld people's dignity and respect.

Requires improvement

Is the service responsive?

Our findings

People told us they didn't have involvement in the planning of their care. One said, "I don't really know anything about it." Another commented, "I would like to be involved, I didn't know I had care plans." A relative told us, "That's one thing they do need to improve on. We haven't been consulted, and neither has [relative] as far as I am aware."

People's care records were generic and not consistently personalised, often containing the same information for each person. Care plans did not reflect people's views about their care, or preferences. There was limited information available about people's likes and dislikes, or their hobbies and interests. There were limited life histories available for some people living with dementia who may be unable to recall details of their past life independently. Staff having access to this kind of information about people could enable them to provide more person centred care and to better understand the behaviours of people living with dementia.

Whilst there was a member of activities staff available in communal areas throughout the day, people who preferred to stay in their bedroom told us that they did not have access to activity and stimulation. One person told us they liked to 'sort' things, but said, "I haven't a big enough table. I asked for a bigger one but they didn't get me one." Another person commented, "Just because I don't go downstairs, I don't get anything to do up here." This person told us about an activity they used to enjoy before coming to live in the service, which they were still capable of doing. However, the service had not supported the person to continue this hobby. The person told us they would 'very much like' to start up this hobby again.

This was a breach of Regulation 9: Person centred care of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

People had an opportunity to feed back their views on the service through regular surveys. We reviewed some of the surveys completed by people, and saw that these were mostly positive. Where negative trends had been identified or negative comments made, there was evidence that these had been followed up and resolved by the manager of the service. People also had the opportunity to attend regular residents meetings, where they could discuss aspects of the service and express their views on its development. Where some people had made suggestions about a certain goal or activity they wished to complete, we saw that the service had fulfilled these goals. For example, one person had wanted to ride a Harley Davidson motorbike, and the service had arranged this for them. Another person had asked to attend a football match, and the service had also arranged for this. This meant that some people felt listened to.

People told us they knew how to complain. One person said, "They gave me a leaflet about complaining when I arrived." A relative said, "I haven't the need to yet, but I would know how to go about it if ever I did wish to complain." The service had not received any complaints at the time of our visit.

Inadequate

Is the service well-led?

Our findings

The quality assurance system in place at the service was not consistently capable of identifying areas of risk. For example, we identified medicines errors and poor medicines administration practice which had not been identified through the regular medicines audits carried out by the management. Audits of the building had not identified areas where grab rails should be present to reduce the risk of people falling, so no action had been taken to minimise these risks.

Incidents and accidents were not consistently monitored for trends. For example, the service had not identified a high level of falls within the service and taken action to investigate any potential reasons behind this.

This was a breach of Regulation 17: Good Governance of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

There was a culture of openness, honesty and transparency within the service. Staff told us, and records confirmed that they were involved in discussions about issues within the service. Different staff groups met on a regular basis to discuss the development of the service and staff team. Staff were encouraged to share learning and discussions were held following safeguarding investigations. Regular clinical meetings were held with external health professionals to discuss people's needs and how these could be better met by the service. Staff told us they found the meetings useful. One said, "It gives us an opportunity to all get round the table and say what we think."

People and staff made positive comments about the management of the service. One person said, "The managers are just excellent. So understanding and they hear you out." Another told us, "They take the time to come and see you and say hello. They're busy people so I appreciate it." A relative said, "[Managers] are very willing to listen and their door is always open." A health professional commented, "The management here are very good. They are proactive, hardworking and really care about the residents."

The leadership of the service had clear goals and aims, and promoted people's right to independence. However, other staff did not always share these goals and aims or were not aware of them. This meant there was not a shared commitment to the future development of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 12.— 1. Care and treatment must be provided in a safe way for service users; 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— g. the proper and safe management of medicines;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent 11.— 1. Care and treatment of service users must only be provided with the consent of the relevant person. 2. Paragraph (1) is subject to paragraphs (3) and (4). 3. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act*. 4. But if Part 4 or 4A of the 1983 Act** applies to a service user, the registered person must act in accordance with the provisions of that Act. 5. Nothing in this regulation affects the operation of section 5 of the 2005 Act*, as read with section 6 of that Act (acts in connection with care or treatment).