City Health Care Partnership CIC

Highfield Resource Centre

Inspection report

Wawne Road
Sutton On Hull
Hull
North Humberside
HU7 4YG

Tel: 01482231736
Website: www.chcpccic.org.uk

Date of inspection visit:
13 March 2018
14 March 2018

Date of publication:
17 April 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Highfield Resource Centre 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.

Highfield Resource Centre is registered to provide care for up to 34 people who may have health, social or dementia care needs. There are two permanent beds and 32 interim beds, which are jointly funded with the NHS to provide rehabilitation and support to people leaving hospital. People that use the service are rehabilitated to go back home or found permanent placements in private residential services. The home is run by City Health Care Partnership CIC (CHCP) after taking over as the legal entity in February 2017. It is located on the outskirts of Hull and has access to good public transport. At the time of the inspection there were 27 people receiving the service.

This first comprehensive rated inspection of Highfield Resource Centre, under the ownership of CHCP, took place on 13 and 14 March 2018 and was unannounced. We found the overall rating for this service to be 'Good'. The rating is based on an aggregation of the ratings awarded for all 5 key questions.

The provider was required to have a registered manager in post. On the day of the inspection we found that the registered manager had been in post at Highfield Resource Centre for the last seven years, but transferred their employment to the new provider just over a year ago. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People were protected from the risk of harm because systems in place detected, monitored and reported on potential or actual safeguarding concerns. Staff were appropriately trained in this area and understood their responsibilities in respect of managing potential and actual safeguarding concerns. Risks were also managed and reduced on an individual or group basis. Recruitment policies, procedures and practices were carefully followed to ensure staff were suitable to care for and support vulnerable people. Staffing numbers were sufficient to meet people's needs. We found that the management of medicines was safely carried out and infection control practices were effectively followed. When events went wrong the provider and staff learnt lessons from them so that the same mistakes were not made again.

People's needs were effectively assessed and staff were given the skills and training to be able to carry out their roles. People received adequate nutrition and hydration to maintain their levels of health and wellbeing. Information about people's needs, ailments and daily demeanour was communicated well across the CHCP services located on site. Premises were safely maintained, suitable for short stay use and though some areas were in need of refurbishment, plans were already in place and work had begun to improve facilities. People's mental capacity was appropriately assessed and their rights were protected.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice. People's consent was obtained.

People received compassionate care from kind staff who knew their needs and preferences. People were supplied with the information they needed to stay in control of their lives, keep their independence and be involved in all aspects of their care. Their wellbeing, privacy and dignity were monitored and respected.

Independence being the main aim of the service meant that person-centred support packages were used to aid recovery and health and these were regularly reviewed. People had the opportunity to engage in some pastimes, activities and such as seeing the hairdresser, but mainly occupation was about recovery. People maintained very good family connections and support networks. An effective complaint procedure was in place and people were able to have any complaints investigated without bias. End of life care was rarely required, but an example of how one person had been supported at this time showed that staff were caring, sensitive and sought the right medical support to ensure a pain-free experience.

The culture and the management style of the service were positive. An effective system was in place for checking the quality of the service using audits, surveys and meetings. Experiences of transition between services were managed well because of good partnership working across CHCP and with other providers. Opportunities for people to make their views known were available and recording systems used in the service protected their privacy and confidentiality of information, as records were well maintained and held securely in the premises.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of harm. Staff were trained in this area and understood their responsibilities. Risks were managed and reduced.

Recruitment procedures were safe. Staffing numbers were sufficient to meet people's needs.

The management of medicines was safely carried out and infection control practices were effectively followed.

When events went wrong the provider and staff learnt lessons so that mistakes were not repeated.

Is the service effective?

Good

The service was effective.

People's needs were assessed and staff were skilled and trained to carry out their roles.

Adequate nutrition and hydration ensured people's health and wellbeing. Information sharing and communication was effective.

Premises were safely maintained and facilities were being improved where needed. People's rights were protected and their consent was always obtained.

Is the service caring?

Good

The service was caring.

People received compassionate care from kind staff.

They were provided with the information they needed to stay in control of their lives and maintain their independence.

Their wellbeing, privacy and dignity were monitored and respected.

Is the service responsive?

Good

The service was responsive.

Person-centred support packages aided recovery and promoted health.

People engaged in pastimes and activities, but occupation was mainly about recovery. People maintained family connections.

An effective complaint procedure ensured complaints were appropriately investigated.

End of life care was sensitively provided.

Is the service well-led?

Good

The service was well led.

The culture and the management style of the service were positive.

An effective quality assurance system identified shortfalls in service delivery.

Experiences of transition between services were well managed, as partnership working was efficient.

People made their views known. Recording systems protected people's privacy and confidentiality of information and records were securely held.

Highfield Resource Centre

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.

The inspection of Highfield Resource Centre took place on 13 and 14 March 2018 and was unannounced. One adult social care inspector carried out the inspection. Information had been gathered before the inspection from notifications sent to the Care Quality Commission (CQC). Notifications are when providers send us information about certain changes, events or incidents that occur. We received feedback from local authorities that contracted services with Highfield Resource Centre and reviewed information from people who had contacted CQC to make their views known about the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with eight people that used the service and two relatives as well as the registered manager, two deputy managers, a nurse from City Health Care Partnership CIC who was based on site, two care leaders and two care workers. We looked at care files for four people that used the service and at recruitment files and training records for four staff. We viewed records and documentation relating to the running of the service, including those for quality assurance and monitoring, medication management and premises safety. We also looked at equipment maintenance records and records held in respect of complaints and compliments.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and staff. We looked around the premises and saw communal areas and people's bedrooms, after asking their permission to do so.

Good

Is the service safe?

Our findings

People told us they felt safe at Highfield, there were sufficient staff to meet their needs, medicines were given to them as needed and the home was clean and tidy. They said, "I know the staff are good people", "Staff make sure I don't fall", "While they are always busy the staff are always around" and "The place is lovely and clean" and "I look after my tablets because staff give them to me each week."

Systems and practices protected people from harm or abuse and risk management ensured people were safe. Staff were particularly aware of maintaining people's safety and security of their possessions because of the high admission and discharge rate of people of different ages, differing life experiences and from a wide range in demographics. Staff demonstrated good understanding of safeguarding principles and procedures.

Risk management was effective with personal and environmental risk assessments being followed with regard to the premises and equipment used. For example, ceiling tracking hoists in five bedrooms were only used subject to occupational therapy assessments being completed and risk assessment documents being in place.

The safety of the premises was assured with maintenance contracts in place under one company for all areas and we saw evidence of the safety checks carried out on utilities supplied, fire alerting systems, the passenger lift and lifting equipment in use. These were all up-to-date. The management team stated that the response from the contractor was extremely good and repairs and replacement of equipment was very timely. The provider had plans to replace the old fire safety system and emergency lighting, which were still functional but needed upgrading.

Recruitment practices were safe and ensured staff were suitable for their roles, which included seeking references and security checks before they started working. Many staff had worked for several years at the service.

Staffing numbers were sufficient with seven staff on duty each morning and six each afternoon, while there were four throughout the night. Two care leaders also worked throughout the day time and one at night. These levels had been increased since the change in provider and there were still a few hours to recruit to.

Management of medicines was safe with care leaders being responsible for ordering and checking stocks as well as administering medicines to people. Everyone that used the service was given a 'Fullers' assessment to determine if they could safely administer their own medicines and we saw that some successfully did so. The medical room was tidy and organised and systems were clear to follow. Room and medicine fridge temperatures were recorded. Medication administration records (MARs) were accurately completed by two staff, signed on administration of tablets and omission codes were properly used. Medicines to be given 'as required' were only given according to written protocols and those subject to special administration regulations, controlled drugs, were given and signed for by two care leaders. Unused medicines were safely disposed of.

The management of infection control in the service was good, personal protective equipment such as aprons, gloves, wipes and sanitising gel was available and domestic staff maintained a clean and hygienic environment all through the premises. Any people on the rehabilitation programme that had wounds had these dressed by the nurses employed by City Health Care Partnership. Two permanent people living at Highfield received support from the community district nursing services.

Discussions with the registered manager and two deputy managers revealed that if a problem or concern arose or something went wrong with a person's care and support that had to be resolved then lessons were learnt from the experience to prevent it happing again. Accident and incident policies and records were in place (records were held on the NHS Datix system), as well as in paper format. Records showed that these were recorded thoroughly, action had been taken to treat injured persons and measures put in place to prevent any reoccurrence.

Good

Is the service effective?

Our findings

People told us they had been assessed for care at Highfield, staff were highly capable of carrying out their roles, the food was very good and they were being supported very well to improve their health and well-being. They said, "I was assessed while in hospital and then asked about the care I needed when I got here", "Staff certainly know what they are doing. They all seem very capable", "The food, is lovely", "I eat very well here and am putting on weight" and "I've been very ill but with the help of the girls I'm now getting there." Visitors we spoke with said, "I have not seen my [relative] look so well since before they went into hospital. They are improving daily, eating well and showing signs of improved strength" and "Oh my [relative] is doing very well, though a fall here did set them back a little bit, which meant their stay has been longer than expected."

Before they received a service at Highfield Resource Centre people were assessed by a 'Trusted Assessor from City Health Care Partnership CIC (CHCP) either while in hospital or at home, a care plan with accompanying risk assessments was put together and the staff at Highfield were informed of their imminent arrival. Once admitted people were immediately provided with 'safe' support regarding their personal hygiene, nutritional, medical needs and mobility. Staff continued the assessment process as part of the support they provided with the aim of rehabilitating people to better health and independence. People were fully involved in this and their choices with regard to their needs were respected.

Staff received training and competence checks to ensure they were skilled to provide care and support, which was supplemented by the consultant, nursing, occupational therapy and physiotherapy services located on site at CHCP. Staff training was monitored, regularly updated and certificated and this was evidenced through training records and certificates held in staff files as well as being confirmed by staff in conversation. Induction, supervision and appraisal were evidenced, though the appraisal system under CHCP was unsuitable for social care staff and was being reviewed before being fully implemented.

Food was freshly cooked on site and people were observed eating in their bedrooms or in the dining room, as was their choice. People's 'malnutrition universal screening tools' (MUST) showed how risks with eating and drinking were reduced and the services of the speech and language therapist were accessed if required. Their medical needs, preferences and religious or cultural requests were taken into consideration and specialist diets as well as choice alternatives were offered. Staff gave examples of when the service provided diabetic, pureed and vegetarian meals as well as Kosher and Halal meat. Support was appropriately given to anyone who had difficulty eating.

The management team, care leaders and staff worked well with other CHCP employees and NHS staff located on site. A daily five minute 'huddle' was held every morning at 11:30am to discuss and share any immediate concerns that had arisen for people throughout the night or early morning. This involved nurses, occupational therapists, physiotherapists, care staff and domestics and with the aim to provide appropriate services (medical, health or social care) could be accessed to prevent issues escalating and to ensure care and treatment was quickly put into operation. Medical and health support from consultants and nurses was also easily accessed with a simple phone call through to the City Health Care Partnership offices on site.

Weekly multi-disciplinary team meetings were also held to discuss people's individual health needs and progress and to decide changes to treatment or support plans. A review of people's packages of care were carried out and their discharge dates were determined. Four 'ward rounds' per week were also carried out with a consultant present to reassess people's medical and health needs. Staff discussed issues or problems with nurses and changes in care and treatment were agreed. Everyone we spoke with felt that relationships with CHCP medical and health workers was excellent.

The premises were adapted to include communal areas, lounges, a dining room, an occupational therapy room and gardens, which people could access. Bedrooms were small, with the exception of eight rooms called chalets and two rooms occupied by permanent service users. Only the chalets had en-suite toilet facilities, but there was a good selection of communal toilets, bathrooms and showers to choose from. Facilities were good and contained suitable equipment for assisting people with mobility difficulties to move, take a bath, use the toilet and get in and out of bed in five bedrooms that had ceiling tracking hoists. Wheelchairs, walking frames, commodes, profile beds and shower chairs (including for people with bariatric needs) were all available when needed and the occupational therapists on site could quickly assess people for the use of any of these.

The premises had undergone some improvements since CHCP had taken over the business, with regard to new fittings in bathrooms and bedrooms for soap, paper, other hygiene needs and grab rails. Other areas that needed improvement were planned for, while costs had been determined and work was being carried out in stages. The physiotherapy room on the upper floor had proved to be too small and so a new one was being created on the ground floor close to the dining room. The laundry/sluice room on the ground floor was also due to be changed to ensure an easier and more hygienic flow of laundry and to separate the laundering from sluicing. While some of the décor was also tired and worn, this was part of the phased alterations that were taking place. The provider was aware of the refurbishment needs and already had plans in place.

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 interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called 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 were being met. The management team had made two DoLS applications for people approximately two years ago and recently had to resubmit them. No other applications had been necessary, as people admitted to Highfield were there on a short-term basis, were assumed to have capacity and almost always did have. Until such time as their continuing assessment determined that their capacity may have been in question, they remained outside of the capacity assessment test. Staff were fully aware of capacity principles and referred people for the test if any doubts were expressed. People were free to leave the service at any time. They had consented to receive rehabilitation by signing their care plans and consent documents for personal details to be shared with health and social care professionals.

Good

Is the service caring?

Our findings

People told us they found staff to be extremely caring and enabling, that they could express their views freely and their privacy and dignity were respected. They said, "The staff are kind and we have some fun between us", "There are some lovely staff here, but I sometimes feel a bit hurried", "I can say what I want about my support and the rehabilitation process, to ensure it suits me", "I'm truly hoping I can go home soon" and "Staff are respectful and make sure I have what I need to manage my personal care discreetly."

Staff were seen and heard to be approaching people with support needs in a caring and kind, but also directive way. The emphasis was on helping people to become independent again so they could move back home as soon as possible and so sometimes there was a fine line between assisting people to do for themselves and 'doing for' them. However, staff were clear about their remit and always asked people to do as much as they could for themselves, which meant they were sometimes seen by people, as one person expressed, as 'pushy'. Discussion among the staff and health professionals in the 'huddle' meeting on one of the mornings we visited had touched upon one person's reluctance to do more for themselves when mobilising and so everyone was aware of and sensitive to that person's feelings. Staff were clearly aware of what they should expect from people with regard to aiding their rehabilitation.

People made their own decisions about getting up for the day, washing and dressing, regarding their meals and cooperating with the care plan devised for them. One explained how certain rehabilitation tasks were still very difficult for them. Another two people explained how their return home was dependent on completion of fitting aids and adaptations to, for example, their bathroom. Everyone was treated individually.

While bedrooms were small they provided some privacy for washing and changing as wash hand basins were located behind bedroom doors and blinds and curtains could be closed. Bathrooms and toilets had locks on doors, which could be opened from the outside in an emergency if required. Staff followed good principles for respecting people's privacy and dignity and demonstrated their commitment to ensuring people felt comfortable when receiving guidance and prompts with personal care and other tasks. Where a person may have needed support with eating this was carried out sensitively, at the person's own pace and in line with risk assessments as initiated by speech and language therapy regarding food and fluid textures.

People at risk of experiencing discrimination or unequal treatment which may result in their needs not being recognised or met on the grounds of age, disability, gender, race, religion and belief, sexual orientation, gender reassignment and pregnancy and maternity status, had come through the service at some point, but the staff were mindful of their responsibility to ensure discrimination did not take place. We were given some examples of how people had been at risk had their needs not been recognised and addressed. For example, one person of a particular religious faith required meat prepared in a particular way and so this as purchased. Another person specifically requested support with personal care only from staff of the same gender, which was respected, while a third person who was homeless was supported to find hostel accommodation, but returned to Highfield when they injured themselves and became homeless again due

to not being able to manage stairs and the layout of the hostel.

The registered manager was aware of the Accessible Information Standard requirements and while they had not formally used the standard criteria for assessing someone they had been instrumental in ensuring people received information in the format they required. In respect of communication needs we were told of one person's admission whose first language was not English. The person's needs were determined using an interpreter while in hospital and again on admission to Highfield to determine their likes and preferences. These were then incorporated into a picture format communication book and along with 'flash' cards staff were able to understand the person's needs and views. Another person was without hearing and while they were adept at lip-reading, the staff also provided written information in the form of a pamphlet on what to expect of the service. Messages were also given to them with use of a pen and paper, where necessary.

Good

Is the service responsive?

Our findings

People told us they were aware of their care plans, thought staff responded well to their needs and that they could complain if they wished to. They said, "I know what has been planned for me and I have physiotherapy every day", "Staff know how I am progressing and I have some home visits planned soon", "I understand I am here for rehabilitation but I don't think I have been told when I can go home, which is something I am desperate to do" and "Staff seem to know how to help me get better and I appreciate their input." They also said, "I am checked in the night and while this sometimes disturbs me I know it has to happen", "I have no reason to complain, though staff do 'push' you to achieve, but I know that's to ensure my independence again" and "While I know who to talk to I am unlikely to complain, as I am not the complaining type."

Care plans for those on the rehabilitation programme were fit for purpose and while they were not as comprehensive as would be expected for a person living permanently in a residential care home, they showed how risks were mitigated and support with daily living tasks and skills was provided. They contained integrated information on risk reduction and the support people needed. Monitoring charts and body maps for recording support given with skin integrity, nutritional intake, output and topical creams were evidenced in people's bedrooms.

Two people that still lived permanently at Highfield had a different style of care plan that was comprehensive with detailed interventions on how best to meet their needs. They also contained risk assessments on several areas of risk, but these were separate. While they could have been reduced in content without loss of effectiveness there was no need to amend them. Both types of care plan provided the level of information staff required to assist people with their independence and/or support needs.

Activities were facilitated and some occupation was offered, but not on any regular or organised scale, so this could be an area for further development. People's recuperation involved visits from occupational and physiotherapists as well as nurses and consultants and much of their day was taken up with exercises and progress assessments, blood tests and blood pressure checks. All of this was about concentrating efforts on recovery and improving health. People had televisions, radios, puzzle books, newspapers and perhaps a small plant in their bedrooms and we saw staff on occasion sitting chatting to people. Visitors played an important role in people's recovery and there were relatives and friends in and out of the service most of the day.

The two permanently placed people had activity logs (records), which showed one of them went out monthly with their key worker either shopping at a local outlet or around the village of Sutton. It showed that they also enjoyed listening to music and watching old films on DVD. We observed this person singing along to some old time music and they looked like they were enjoying the experience. A mobile hairdresser visited every Wednesday and people had their hair washed, cut and set as they wished. We saw several people use this facility on the second day of the inspection.

The provider had a complaint policy, procedure and records in place. We saw that complaints had been

addressed appropriately to people's satisfaction. Mainly they related to food provision, staffing levels and medicines management. Discussion with the registered manager and deputies revealed that changes had been implemented so that menus were renewed seasonally, more choice was offered and tea time afternoon cream teas were planned as a change to usual tea meals. Staffing levels had increased by one extra staff member on duty across the 24 hour period and medicine procedures had been tightened up with more audits and checks carried out.

We saw that while Highfield Resource Centre was a rehabilitation service there had been a small number of deaths in the last 12 months: two unexpected. End of life care was sensitively provided with the support of nursing and consultant professionals. Some staff had completed training on 'end of life' care and they spoke about the privilege that it was to be able to support people at that time in their lives. We were told about one person who had expressed the wish that they be cared for in Highfield at the end of their life and this had been respected.

Good

Is the service well-led?

Our findings

People told us they found everyone that worked at Highfield Resource centre to be clear about their roles and responsibilities, the service was open and inclusive, their views were listened to and their support was effectively managed. They said, "Staff know when they should be here and what they should be doing on shift", "Everyone is so very helpful", "I make my opinions known and talk to staff whenever I need to", "The whole package is interlinked and everyone seems to know where they fit in."

Visitors told us, "The management and staff work well together and they all liaise well with health professionals" and "I have seen great results with my [relative's] improvement and I am certain this is down to how the staff work with the health care workers." Staff also felt that everyone involved at Highfield Resource Centre played an important role in the overall service provision, worked as a team and took pride in providing a good service. One said, "We have a very strong leadership team and managers will assist us with care and support if necessary." Other staff described the culture of the service as supportive, friendly and enabling and expressed that Highfield Resource Centre was a good place to work. One staff member said, "I am proud to work here."

The provider was required to have a registered manager in post and on the day of the inspection there was a manager in post, who had been the registered manager for the last seven years, but transferred their employment to the new provider just over a year ago.

The provider and registered manager were aware of the need to maintain a 'duty of candour' (responsibility to be honest and to apologise for any mistake made) and told us about any instances where this had been necessary. Notifications were also sent to us regarding accidents, incidents and events and so the service fulfilled its responsibilities under its registration requirements.

Staff were vaguely aware of the organisation's aims, vision and values and while they could not voice what these were they were able to express the essence and meaning of them through recollections of their practice and reflection. They strove for excellence, respected people's diversity, looked for creative ways to empower people and cooperated well with their partners in care. Staff said that the management team were supportive, open and transparent and listened to people's views and those of the staff team. They also found care leaders to be helpful and the first colleagues they would go to in the chain of command.

City Health Care Partnership CIC (CHCP) had systems in place to carry out independent audits of the service provided at Highfield Resource Centre and results of these were analysed and fed back to the management team and then to staff in meetings, so that improvements could be made where necessary. In-house audits were completed on the management of medicines and infection control practices. These were also analysed and used to determine the changes needed to improve staff practice.

People may not have had influence over how the service was run, but they certainly influenced how their individual care package and treatment was devised and delivered so that it met their individual needs. People contributed to the treatment and support they received in regular reviews of their care and when

they were visited by consultants carrying out what was known as 'ward rounds'. People passed information to staff and staff picked up on people's development, improvement or deterioration during their observations throughout the week. All of this was discussed in weekly multi-disciplinary team meetings in order to achieve the best possible support for people.

Learning was always taking place within the service, for example, all staff were soon to be given instruction on how to make basic checks of people's blood pressure, temperature and pulse rate. This was so that they could alert the nursing and consultant team to any unwanted negative changes in people's general health, which could be an indication that something was medically wrong with them.

The registered manager, deputies and service staff all worked well in partnership with other agencies. People admitted to Highfield Resource Centre from hospital or their own homes usually did so with accompanying assessment and support plan documentation, which was completed by a 'Trusted Assessor' employed by CHCP. Staff then liaised with hospital staff or CHCP nurses, occupational therapists, physiotherapists and nutritionist to ensure they were providing the care and support decided for people. Anyone moving to another care provider because they were unable to return home was transferred according to set plans, when deemed to be healthy to do so, and accompanied by appropriate documentation, information and medication to enable a smooth transition.