Burlington Care (Yorkshire) Limited

Highfield Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Highfield Care Centre is a 'care home' which provides accommodation and personal care for up to 88 older people some of whom may be living with dementia. At the time of the inspection there were 59 people using the service. Accommodation is spread out over four distinct units of the home. At the time of the inspection three of these were in use.

People's experience of using this service and what we found
Medicines were not managed safely. Medication administration records did not always show medicines had been administered as prescribed. Medicines had been audited; however, the audits were not effective in ensuring safe management of medicines. This put people at risk of harm.

Not enough staff were deployed across the service. This meant there was a risk people did not always receive the care, support and supervision they needed. Systems were not in place to accurately calculate safe staffing levels. People did not have enough access to meaningful activities.

Most people and relatives we spoke with told us they or their family member felt safe and were happy with the care at the service. However, we found some risks to people's health and welfare were not properly recorded. This meant people were at risk of avoidable harm. Care records did not always contain enough information or had inconsistent information about people's needs. This meant staff were not always provided with the information they needed. This put people at risk of not having their needs met.

Systems and procedures to provide management oversight and monitor the safe delivery and quality of care provided to people were not effective. Audits were not always completed and when they were, they were not effective in identifying areas of improvement. The service was not well-led. Leadership was ineffective; staff lacked support and guidance. Systems and processes were not robust enough or fully established to learn from safety-related incidents.

People told us they liked the staff and said they were kind and caring. People shared their positive experiences of living at the service. They said they were treated with dignity and respect by staff. The provider told us they were increasing staffing levels on some shifts. We have not been able to review the sustainability of these changes.

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 29 August 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection sustained improvement had not been made and the provider was again in breach of the regulation found at the previous inspection and further breaches were found.

Why we inspected
We undertook this focused inspection to check the provider had followed their action plan and to confirm they now met legal requirements. The inspection was also prompted in part due to concerns received about risk management in the service as we had received high numbers of notifications regarding unwitnessed falls and physical altercations between people who used the service.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this 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.

We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this full report.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection.

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

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to staffing, medicine management, good governance and record keeping.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration,

we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Highfield Care Centre

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
The inspection team consisted of three inspectors, one of these being a medicines inspector, a specialist advisor in governance 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. The Expert by Experience supported the inspection remotely using telephone facilities to speak with people who use the service and relatives.

Service and service type
Highfield Care 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.

The service had a manager registered with the Care Quality Commission; however, they had left the service in July 2021. A manager had been recruited to replace the registered manager and they left during the inspection. Following this, the deputy manager was made interim manager. The registered manager 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
We gave a short period notice of the inspection on the first day. Due to the COVID-19 pandemic we wanted to review documentation remotely and make arrangements to speak with people, relatives and staff by

telephone after our site visit. This helped minimise the time we spent in face to face contact with the management team, staff and people who used the service. The inspection was unannounced on the second day.

What we did before the inspection
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.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, local safeguarding team and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke face to face with two people who used the service and by telephone with two people and three relatives about their experience of the care provided. We spoke with the interim manager, regional manager, deputy manager, four care staff, a housekeeper, a kitchen assistant, the cook and an agency staff member. We spent time observing the care and support people received. We reviewed 30 people's medicines records and nine people's care records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We continued to seek clarification from the service to validate evidence found.

Inadequate

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

Using medicines safely
• People missed some doses of their prescribed medicines because there was no stock available for them. Stock checks for some medicines and records about creams showed they had not been given as prescribed or incorrect doses had been given.
• People did not always have written guidance in place for staff to follow when medicines were prescribed to be given 'when required' or with a choice of dose. This meant staff did not have the information to tell them when someone may need certain medicines or how much to give.
• Information was missing to help staff give covert (medicines disguised in food/drink to administer unknowingly) medicines safely.
• Records about medicines did not always show they were managed safely. Staff did not complete records of administration accurately.
• Two people were given eye drops which were out of date.
• Records about the time medicines were given were not complete and did not record all doses given so it was not always possible to be sure a safe time interval was left between doses.
• Medicines were not stored safely. The fridge temperature on the day of inspection showed insulin had been stored outside recommended temperatures.
• We raised these concerns with the interim manager who told us they would review medicines management systems.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate medicines were safely managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• Not enough staff were deployed across the service to meet people's needs. The provider used a dependency tool to calculate staffing levels. However, the new regional manager had identified this was

inaccurate and did not identify people's current needs.
• Rotas showed there were 14 occasions between 26 July 2021 and 22 August 2021 when staffing levels were below those described as needed by the interim manager of the service.
• We saw there were occasions throughout the inspection when no staff were present in communal areas. This meant people who were at risk of falling or being involved in physical altercations with others may not have been supported in a timely manner.
• Staff were overstretched, and their care delivery was tasked based. They all told us the numbers of staff on shift were insufficient. They said they had little time and opportunity to support people to participate in meaningful activities or to sit and chat with them. One staff member said, "Can't spend as much time as you would like with people, can't have a chat, it's all about tasks." Another told us people's needs were met but lack of staffing led to rushing, getting behind, skipping the nice things and not being able to spend quality time with people.
• A relative commented that staff seemed worn out and were always busy. We saw records which indicated errors had occurred and staff had reported being busy and feeling drained as the cause of these errors.

Staff were not deployed in a manner which promoted safety and person-centred care. This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Recruitment systems were robust and made sure that the right staff were recruited to support people. Appropriate Disclosure and Barring Service (DBS) checks and other recruitment checks were carried out as required by the regulations.

Assessing risk, safety monitoring and management
• A range of risk assessments were in place for people which covered areas such as skin integrity, diabetes, falls and mobility. Some of these contained inconsistent and incorrect information. This could lead to needs being missed or overlooked. For example, two people with risks regarding diabetes had conflicting information within their records about support needed with their diet. The interim manager took action to address this at the inspection.
• Supplementary records to support risk management were poorly completed. A person who was at risk of pressure damage had records in place that showed they were not re-positioned as frequently as the care plan indicated. Another person had gaps in the record of their food and fluid intake.
• Another person's records indicated risks due to refusal of personal care interventions. The records lacked detail on how to support them with a shower. However, staff could describe the person's needs and how they supported them safely.

We found no evidence that people had been harmed however failure to maintain accurate records for people who used the service was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The service needed repair and refurbishment in some areas. This included the main kitchen and repairs to a water damaged ceiling. There was no full refurbishment plan in place and no management oversight of how this would be done.
• There was a lack of maintenance support and management oversight of maintenance and records. For example, water temperature checks had not been completed since June 2021 and weekly fire alarm tests had not been carried out weekly.
• Cleaning records showed frequent gaps and the interim manager spoke of the 'constant battle' to ensure staff completed these after cleaning had taken place. Staff meetings and supervisions indicated how staff had been reminded. This was not proving to be effective.

We found no evidence that people had been harmed and the management team took action to address the maintenance issues we identified. However, the lack of management oversight was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
At our last inspection we identified improvements were needed to infection prevention and control practice. This was a breach of Regulation 12 (Safe care and 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 element of Regulation 12.

• 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 assured that the provider was using PPE effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Overall, the service was clean. However, we noted some areas such as the staff toilet, pieces of equipment and carpets needed improved cleaning. People and relatives told us their or their family member's rooms were kept clean and tidy. One person said, "It's clean; it's very clean. I have no grumbles."
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were somewhat assured that the provider's infection prevention and control policy was up to date. The service had not completed individualised risk assessments for people or staff to determine whether they were more at risk if they contracted COVID-19.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• There was a high number of safeguarding concerns. Most of these concerns had not been closed to show actions had been taken and did not indicate areas of learning to prevent re-occurrence.
• There were systems in place to monitor accidents and incidents, however, there was a lack of learning from these to prevent re-occurrence. There continued to be a high number of falls and physical altercations between people. These often involved the same people.
• Most people told us they felt safe and looked after by kind and caring staff. One person said, "I feel very well looked after and the staff are very nice, and everything is okay." However, another person indicated they were upset and anxious as another person who used the service had been going in their room and moving their belongings.

Inadequate

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 now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service was not well-led. The registered manager had recently left the service. A new manager had been appointed and they left the service during the inspection. The deputy manager was then made the interim manager. They told us there had been five changes of regional manager support in the last year; the most recent commencing their role during this inspection.
- Governance and quality checks were not robust enough and had failed to identify areas of risk which had placed people at risk of harm.
- Audits, when completed had not identified concerns we found such as those with staffing levels, medicines, risk management records, safety records and premises checks. We found care records did not always record people's needs consistently.
- Systems for identifying, capturing and managing safety and risks within the service had been ineffective. There was a lack of evidence of management and provider oversight to demonstrate how improvements could be made. The service action plan had a high number of overdue actions and no plan in place to show how these were going to be addressed.
- Lessons were not learnt from accidents, incidents and feedback given to ensure service improvement and safe care for people. A staff survey had been undertaken in March 2021. Staff had expressed concerns and dissatisfaction in several areas. These included, lack of activities, communication, staffing levels and being given the support they needed to carry out their roles. There were no action plans in place to record remedial action taken.

Systems were either not in place or robust enough to demonstrate the quality and safety of the service was effectively managed. The provider had also failed to maintain an accurate and contemporaneous record in respect of each person who used the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We discussed these concerns during the inspection. The interim manager and new regional manager told us of plans they had to improve governance and records. This included the introduction of lessons learned records, meetings with staff and a review of the dependency levels of people in the service. None of this had been embedded in the service at the time of our inspection.
- Relatives told us they thought the service was managed well but were aware of the changes in management. One relative said, "It remains to see what happens now."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Staff spoke positively about the interim manager and the day to day support they received from them. Records showed staff did not always receive regular supervision meetings.
• Staff provided mixed feedback about how the service operated overall. They spoke about people in a kind and caring way but expressed concern about how staffing levels impacted on how much time they could spend with people.
• We observed there were limited opportunities for people to engage in person centred activities. Staff told us the staffing levels in the service affected this. Some people and relatives told us they did not think there was enough to do. However, people and their relatives were happy with the care provided. One person said, "All I can say is I am happy about the way they treat you; with respect. They do their best to solve any problems you have got, and I am quite happy here."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• The provider had limited systems in place to gather feedback from people, their relatives and members of staff. The provider did not hold regular meetings with people who used the service or their representatives. No recent surveys had been undertaken to gain people's views on the quality of the service. The interim manager told us they used 'managers walk rounds' to gather people's views. The records of these were not detailed and did not show if any actions were identified.
• Staff meetings took place, but records showed little or no attendance at these. It was not clear how important information about the service was disseminated, embedded and used to sustain improvements.
• There was evidence of working with healthcare professionals and commissioners.
• Relatives told us they felt involved in the care of their family members and staff communicated well with them when there were any changes. One relative said, "Communication is absolutely fine. Anything that happens to [family member], they phone up."

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 provider was meeting the requirements of the duty of candour. The duty of candour is a legal duty for providers to act openly and honestly, and to provide an apology if something goes wrong. People and relatives told us any concerns they had were addressed by the management team when discussed.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 always managed safely.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate the quality and safety of the service was effectively managed. The provider had also failed to maintain an accurate and contemporaneous record in respect of each person who used the service.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient numbers of staff were deployed.

The enforcement action we took:

We served a warning notice.