Highbury Nursing Home Ltd

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

Summary of findings

Overall summary

About the service
Highbury Nursing Home is a residential care home providing personal and nursing care to up to 38 people. The service provides support to older adults and people living with dementia. At the time of our inspection there were 22 people using the service. The home was purpose built and contained communal lounge and dining areas. People had their own rooms. Some had en-suite facilities, and some did not. There was a shared garden area. At the time of the inspection rooms which could be used to accommodate 2 people sharing were not being accommodated by 2 people.

People's experience of using this service and what we found
We found the provider had failed to consistently investigate incidents and accidents. This meant that some risks of abuse or neglect were not considered or shared with the local authorities safeguarding team. Some areas of the home still required maintenance and repair making them difficult to clean adequately.

Many care staff still required training in some key areas such as the Mental Capacity Act, Dementia and other health conditions for which some needed care. Care plans contained information about people's medical needs but not much detail about their wishes and preferences. People were supported by a fully recruited staff team.

More guidance was needed for staff to ensure people were supported to be as independent as they could be. People and their relatives described the staff team as caring. Meetings had begun for people to talk about ways in which the service could improve.

Efforts to provide information to people in a way they could understand had improved. The provider had recruited more staff to support people with activities and interests. People and relatives provided positive feedback about improved access to activities.

Systems to monitor the quality and safety of the service had failed to enable the management team to identify some of the concerns we found on inspection. Risk monitoring systems had failed to highlight some risks to people around the home. This left people at possible risk.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence, and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there was a person using the service who had a learning

disability.

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 inadequate in all key questions (published 22 February 2023). At the last inspection there were 9 breaches of regulation in relation to the following areas: People being treated with dignity and respect, the leadership and oversight of the service, the safety and well being of people living at the home, how people were protected from the risk of neglect and abuse, meeting people's nutritional and hydration needs, providing care in the way people wanted it, the need to obtain consent from people, how staff were recruited and the training and support offered to staff. We carried out enforcement activity to place conditions on the provider's registration to support them to improve in this area. These conditions remain in place.

At this inspection we found sufficient improvement had not been made in some areas and the provider remained in breach of some regulations.

This service has been in Special Measures since 01 March 2023. During this inspection the provider demonstrated that improvements have been made in some areas. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

The overall rating for the service has changed from inadequate to requires improvement based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.
You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
This inspection has identified continued breaches in relation to how people were protected from risks of abuse and neglect, how people's safety and well-being were monitored, the training provided to staff and how effective the systems leadership had put in place to make sure people received good care. We will continue to monitor the improvement within the service through existing conditions we have placed on the providers registration. This includes sending us monthly reports of action the provider has taken to monitor and make improvements within the service.

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 request reports to be sent to us monthly to monitor the planned improvements. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Highbury Nursing Home

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 Health and Social Care Act 2008.

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 was completed by an Inspector, an Assistant Inspector, and a Specialist Nurse.

Service and service type
Highbury Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Highbury Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.
A new manager was in post and had submitted an application to register. We are currently assessing this application.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 7 people who were living at Highbury Nursing Home about their experience and views of the service. We spoke with 9 relatives about their experience of care provided. We spoke with 13 staff including, the owner, the manager, the deputy manager, care home assistant practitioners, nursing staff, an activity coordinator, members of the domestic staff team, the maintenance operative and day and night carers. We reviewed a range of records. These included 6 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and staff supervision. We reviewed a variety of records relating to the management of the service, including policies and procedures. We also spoke with a professional who worked regularly with the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection there was a lack of robust processes to ensure people were safeguarded from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13

- The provider had not fully protected people from the risk of abuse and improper treatment. They had failed to identify some incidents needed further investigation to determine whether people had been abused or treated improperly.
- The provider had failed to notify the local authority's safeguarding team when concerns of the risk of possible abuse had been identified.
- We saw a cut on a person's arm for which a body map and incident form had not been completed. Although there was a procedure in place for recording and investigating unidentified injuries, in this case it had not been followed. As the cut had not been reported appropriately, there had been no investigation to consider how the injury occurred or whether the local authority's safeguarding team should be notified.
- When concerns of possible abuse had been identified, the provider could not always demonstrate these had been investigated thoroughly.
- We saw for one person who had conditions relating to their Deprivation of Liberty safeguards (DoLS), the provider was not recording and monitoring how this condition was being met. A plan was put in place during the inspection to monitor this.
- Although there were systems in place to support learning lessons when things had gone wrong, these were not effective. Not all incidents and accidents were being identified and investigated fully. This meant people were at risk of abuse or improper treatment.

Processes to ensure people were safeguarded from abuse and improper treatment were not robust and effective, this was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, the manager took steps to address some of the concerns. Concerns were shared with the local authorities safeguarding team and internal investigations were commenced.

Assessing risk, safety monitoring and management

At our last inspection we saw evidence of harm to people. Systems were either not in place or not robust enough to demonstrated safety was effectively managed, this had placed people at risk of further harm. 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

● Systems were in place to monitor people's health and safety, however they had failed to identify the risk of not securing the doors to the stairs on the second floor. At the time of our inspection a person whose room was on the second floor was able to mobilise independently. There was no risk assessment in place to consider whether access to the stairwell posed a risk to the person's safety. This left the person at possible risk.
● Regular environmental checks had not identified the risk of failing to lock storage cupboards on all floors. We saw PPE and incontinence products in storage cupboards which can be a choking hazard to some.
● Damage to walls in people's rooms was either in need of repair or in some cases had been repaired to a poor standard. This meant these surfaces would not be easy to clean and presented an infection risk. The home was under a programme of planned maintenance, but it had not been completed. We also noted a breakfast table with a surface too damaged to clean effectively. Environmental checks had failed to identify the need to replace this. A damaged floor in a downstairs bathroom was also in need of repair and had not been identified.
● We saw thickener prescribed for people with a choking risk left on a drinks trolley in the lounge whilst drinks were being given out. As thickener can be dangerous if swallowed in powder form it must not be left where people can access it.
● Where a person was known to experience periods of distress or agitation, there was little guidance for staff about triggers. There was no evidence steps had been taken to analyse incidents to learn more about what could be done to support the person during times of distress. Listed examples of agitation in the person's care plan included basic efforts to communicate their needs. This meant the person was at risk of inappropriate or ineffective support from staff at times of distress.
● People's care plans did not always include clear guidance about who could use a call bell to seek assistance and who could not. In cases where people could not use a call bell to alert staff, there was not always clear guidance on how staff could ensure people remained safe and their needs were met. A staff member we spoke with seemed unsure about whether a person was able to use a call bell or not. This left people at risk of not having their needs met in a timely way.

Systems to monitor people's health and safety were not always robust or effective. This left people at risk of possible avoidable 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.

During the inspection the management team took steps to address the concerns we highlighted. They advised that doors at the end of corridors accessing the stairs would be locked. A best interest's decision was made and the person on the second floor who could mobilise independently was moved to a ground floor room for their safety. Storage cupboards were locked during our site visits. The breakfast table was replaced, and the damaged bathroom floor was added to the maintenance list for repair.

● We did see improvements in people's risk documentation for health conditions, such as choking risk, falls risk and wound management. We saw such risks were shared regularly at handover. Monthly reviews of wound care and falls risks were completed. Staff knew about these risks and understood how to protect

people from choking risk and improve people's wound care. We saw 1 person who had had pressure wounds which had fully healed as a result of effective wound care.
● There were also significant improvements in the management of fire safety in the home. Fire safety equipment, as well as other equipment used for people's care, was safely maintained. Staff understood how to respond in the event of a fire.

Staffing and recruitment

At our last inspection we found the provider's failure to operate robust recruitment practices was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● The provider had taken steps to significantly improve recruitment practices. Pre-employment checks had been introduced to verify staff suitability for their roles. This included the use of Disclosure and Barring Service (DBS) checks. These provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● An induction process had been introduced. This enabled new staff to familiarise themselves with policies and procedures. New staff also completed competency checks and had their practice observed to ensure it was safe and appropriate.
● People, their relatives and the staff team told us there were enough staff to support people safely. We saw staff were unhurried and had time to spend talking to people. The manager told us they had a team of bank staff who could be called upon if needed. One staff member told us, "Yes there are enough staff… if someone is off sick, they are covered."
● The provider told us they have a full nursing and care team. There had been no recent agency staff use at the time of our inspection.

Preventing and controlling infection

At the last inspection the provider had not taken reasonable steps to protect people from the risk of infections. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider remains in breach of Regulation 12 (Safe Care and Treatment), enough improvement has been made at this inspection with regard to preventing and controlling infection. Systems to manage preventing and controlling infection no longer contributed to this breach.

● Damage to walls, particularly in bedrooms had either not been repaired or in some cases been repaired to a poor standard. This made cleaning these areas difficult. The provider told us many of the rooms were still on the schedule to be redecorated. A breakfast table had a very worn surface which made cleaning it very difficult, it was replaced during the site visit.
● Shared areas of the home, such as the lounges on the ground floor, had been redecorated and looked cleaner and more appealing to those living there.
● At the last inspection we found a lack of robust cleaning schedules. At this inspection more robust cleaning schedules were now in place. Quality checks were completed to ensure cleaning was of a good standard and high use/touch areas were cleaned regularly. Deep cleaning schedules had also been

introduced.
● Previously staff had not received training in infection prevention. At this inspection we saw staff had received training to support effective infection prevention control practices.
● The provider now had an infection prevention and control policy in place. The manager was knowledgeable about what steps would need to be taken in the event of an outbreak of COVID-19.
● People and their relatives told us they were happy with the cleanliness of the home.

Visiting in care homes
The provider's approach to visiting was in line with current government guidance. People were able to receive visitors as they wanted to.

Using medicines safely

At the last inspection we found systems were either not in place or robust enough to demonstrate safety in the management and administration of medication. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Although the provider remains in breach of Regulation 12 (Safe care and treatment), enough improvement has been made at this inspection about how people were supported to take medicines. Systems to manage medicines no longer contributed to this breach.

● At this inspection we found significant improvements in how people were supported to take their medicines. At the last inspection we found staff did not always have clear guidance on how and when to apply creams. At this inspection we saw staff had clear instructions for the use of creams. Body maps were used to show specifically where creams should be applied.
● Staff had clear written guidance on when to offer people medicines which were to be administered 'as needed' (PRN medicines).
● Staff who were administering medicines had completed recent training and competency checks. This helped ensured they were supporting people to take their medicines safely.
People told us they were happy with how they were supported to take their medicines. One person told us, "They bring [my medicines] to me on time. I have never run out."
● At the last inspection we found gaps in medicines administration records (MARs). At this inspection MARs were complete and there were no gaps in the records we reviewed.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At the last inspection the provider had failed to ensure staff received appropriate support, training, supervision and appraisal. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) 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 18.

● We found most care staff had not received training in several areas important to their role. At the time of our inspection a person with learning difficulties was living at the home. Staff had not had training in this area in line with Government guidance. Staff lacked insight into the ways in which a person with learning disabilities may need additional support.
● Most care staff had not received training to support people with specific needs such as diabetes, epilepsy or living with dementia. Although the nursing team had had training in these areas, the provider could not be fully assured staff would know what specific signs to look out for to enable them to support people effectively.
● The care staff had not received training in control of substances hazardous to health (CoSHH). We asked the manager about this who advised this training was mainly for the domestic staff team. Consideration had not been given to the use of other potentially hazardous substances care staff encounter and use to care for people, for example hand sanitiser.
● Care staff had not received training in Mental capacity and Deprivation of Liberties Safeguards (DoLS). They did not fully understand the implications of DoLS and what this meant for people.

The provider had failed to ensure staff received all the training needed to support people effectively. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had put in place some mandatory training which had been completed by all staff, including safeguarding, manual handling and first aid. They advised they did have plans to further expand the training in most of the areas we identified as a concern but had not had time to complete all of this since our last inspection.
● A robust supervision procedure was now in place at this inspection. All staff we spoke with told us they

had received recent supervision. They also told us they felt supported by the management team and the provider. One staff member told us, "The owner comes to speak to us, he is supportive."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At the last inspection we found there had been a failure to assess people's needs which was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

● Efforts had been made to improve the assessment of people's needs and choices, but there was still need for further improvement.
● People's care plans included guidance about their basic health needs. However, there was not always much information about their life history, wishes and preferences, or their protected characteristics under the Equality Act (2010). Very basic information had been sought at pre-assessment in some cases, but nothing further had been done to expand upon this. For example, some people's life history only had one sentence of information.
● On discussion with staff some knew about people's needs and preferences better than others. The management team advised in some cases little was known about people who could not easily express their wishes themselves. Steps were being taken to contact people's friends and family in these cases, but this was still a work in progress.
● Although there was little evidence people had contributed to their care plans, basic care reviews had been held with them and their loved ones. Relatives told us they had been involved in reviews and felt more consulted, However this had not always resulted in a more detailed view of people's needs and wishes.
● The manager explained staff were working on obtaining more detailed information, including 'all about me' plans which had been commenced for some. However, these plans in some cases contained inaccurate information. For example, one person's plan stated they did not have any hearing issues, but in their care plan it stated they were 'profoundly deaf.' The manager agreed these plans needed more time and attention to become more meaningful to people and staff.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At the last inspection the provider had not consistently acted in accordance with the requirements of the Mental Capacity Act 2005. This was a breach of Regulation 11 (Need for Consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 11.

●The provider had taken steps to improve how the service worked in line with the principles of MCA, but further work was needed.
● Training had not been provided for all staff in the requirements of the MCA. Some staff did not fully understand the principles of MCA and what this meant for people. For example, at the time of the inspection there was no one living at the home for whom it was legal and safe for them to leave unaccompanied. However, staff were not always clear about this. This meant there was a continued risk people may not have their rights under the MCA protected. We highlighted this to the manager who stated work was already underway to provide training to all staff in MCA, but this had not been completed by all staff yet.
● We saw in some cases consent to treatment had been signed by a staff member. For example, a person who had loved ones who could sign consent legally upon their behalf had decisions signed for by a staff member. This included consent to receive care and treatment. The manager agreed this needed to be addressed and consent to treatment should be signed by the person or a legally suitable representative.
● At the last inspection best interest's decisions had not always been recorded when a person was being restricted in some way. For example, if a sensor was in place to monitor their movements in their room. At this inspection we saw best interests' decisions were recorded. There was no evidence anyone other than the staff had contributed to these decisions. In some cases, people had relatives or representatives with legal authority to make decisions on their behalf. There was not always evidence that the relevant people had contributed to the specific best interest decisions. People's friends and family had been involved in reviews of the person's care, however clearer documentation was needed to show who had contributed to the best interests' decisions. This would ensure efforts had been made to represent the person's wishes in the decision.
● At the last inspection we found some people had not had their mental capacity assessed and DoLS had not always been applied for when needed. At this inspection we found people had mental capacity assessments in place. Everyone who needed a DoLS had one applied for. A system was now in place to monitor when DoLS needed to be reapplied for.

Supporting people to eat and drink enough to maintain a balanced diet

At the last inspection we found there was a failure to meet people's nutritional and hydration needs, this was a breach of Regulation 14 (Meeting nutritional and hydration needs) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 14.

● Although we found 1 person was in their room without access to a drink, generally we saw people had access to drinks as needed. Staff provided the person with a drink as soon as it was highlighted, they didn't have one. People were given food to meet their specific needs.
● People's dietary needs had been assessed and staff knew about them. For example, staff knew who needed thickener in their drinks to reduce choking risk. They also knew how people's food needed to be prepared to meet their needs. This information was included in handovers as a reminder to all staff. This

enabled people to receive their food and drinks safely in the way they needed them.
● At the last inspection we saw people who were losing weight or at risk of losing weight were not being adequately monitored and supported with this risk. At this inspection we saw people at risk of weight loss were monitored and weight action plans were completed. We saw people deemed at risk were being weighed more frequently and their progress was reviewed. Concerns about weight loss were discussed with the GP to agree action plans.

Staff working with other agencies to provide consistent, effective, timely care;
Supporting people to live healthier lives, access healthcare services and support
● At the last inspection we saw the provider had not always liaised effectively with other professionals to ensure people's health and care needs were met. At this inspection we found referrals to the local authority's safeguarding team had not always been made when needed.
● At the time of the inspection the provider had not yet established links with a dentist to provide regular dental care for people. The management team advised efforts were being made to find a dental service.
● We saw evidence of liaison with other health professionals as needed, such as occupational therapy team, the GP and opticians. For example, a person who needed assistance to mobilise had been referred to the occupational therapy team to be assessed for a mobility aid.
● At the last inspection we found there was not always clear documentation of guidance given by professionals for staff to follow. At this inspection we saw improved records of professional guidance for staff.

Adapting service, design, decoration to meet people's needs
● The physical environment needed adaptation to take into consideration the needs of people living with dementia. For example, although there were clocks around the lounges and one showed the date on it, there was no clearly visible day, date, and time to help people to orient themselves. People's rooms had their names on the doors. Efforts had not been made to personalise them to help people find their rooms and feel they were their own.
● The home was undergoing a programme of redecoration and the lounges had been refreshed. However, some of the bedrooms were still in need of repair and redecoration.
● At the last inspection we saw the home was cluttered and items were stored in corridors and bathrooms. At this inspection the home was uncluttered. Hallways were clear and free from trip hazards for people.
● Menu options were presented in large print and picture format in the lounge so people could see what was available each day easily.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant although most people told us they feel well-supported, cared for or treated with dignity and respect, there were still some areas of improvement needed.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

At the last inspection the provider failed to ensure service users were always treated with respect and dignity whilst receiving care and treatment This was a breach of Regulation 10 (Dignity and Respect) of The Health and Social Care Act 2008 (Regulated Activities) Regulations.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 10.

- We saw continued widespread use of protective clothing at meal and drink times, this was noted at the last inspection. However, this did not appear to be causing anyone distress. We saw an overall improvement in how people's dignity was upheld and how they were respected by staff.
- Care plans did not always detail enough information about what daily tasks people could do for themselves to promote independence. Some staff we spoke with were not sure about how much individuals may be able to do for themselves. We raised this with the manager who agreed this needed to be expanded upon in people's care plans.
- Staff had received training in caring with dignity and were able to describe ways in which they respected people's privacy and dignity. At the last inspection we saw examples of people being treated in an undignified way. At this inspection we did not see this. People received care behind closed doors. Staff knocked before entering people's rooms. Privacy screens were used to promote privacy when they were receiving assistance to mobilise or being helped to reposition in a lounge where others could see.
- At our last inspection 1 person living at the home was walking. At this inspection 4 people were walking with some level of support and were being encouraged to do so. Staff were spending time supporting people to become more independent with their mobility.
- At the last inspection most people were using plastic spouted beakers. Assessments had not been completed to establish who needed them. This meant people were being unnecessarily restricted. At this inspection people's needs and preferences had been considered. We saw a variety of cups and beakers in use according to what people needed and wanted.
- We received mixed views from people about the care they received. One person told us, "Not all the carers are nice." Most people told us they thought the carers were good. One person said, "[The carers] are very good, they know me well."

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

●Care plans did not always demonstrate how people were involved in decisions about their care. It was not always clear people who were unable to make some decisions for themselves had had the support of appropriate others to make decisions on their behalf. Many people had been involved in basic reviews of their care and their loved ones had participated.

● A residents meeting had been held and more were planned to give people the opportunity to give feedback about the service. One person had been nominated as an ambassador for the people living at Highbury Nursing Home.

● People had been asked to complete surveys regarding the care they received. The manager told us about how people's suggestions had been put into action. For example, one person had been taken for a trip out to a local pub at their request.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

At the last inspection systems for ensuring people's care and treatment was appropriate, met their needs and reflected their preferences were not being used effectively. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 9.

● At the last inspection we found people's care plans were not always person centred. They did not always include details of people's personal history, individual preferences, or interests. At this inspection we saw some steps had been taken to improve the personalised aspects of people's care plans, but more work was needed. Care plans contained information about people's basic care needs but were not yet very personalised.
● At the last inspection we found care plans lacked clear guidance for staff regarding people's medical conditions. At this inspection we saw improvements to the guidance for some specific conditions. For example, we saw clear guidance for monitoring risks of pressure wounds.
● At this inspection we did not see examples of people's preferences being disregarded as we had at the last inspection. However more consultation with people and relatives was needed to create more detailed plans about how people wanted to receive their care.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

At the last inspection the provider had not ensured people always had all the necessary information about their care in a way they understood. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

● The provider had taken steps to meet their responsibilities under the Accessible information Standard. There were still improvements which could be made for people living with dementia. For example, we saw pictures of meals were available to show what options were in the menu. However, offering people living with dementia plated options of meals known to be appealing to them is a better way to ensure they are making a more meaningful choice.
● People's care plans were not always in a format which could help them understand. For example, people who would benefit from large print or pictorial references in their care plans did not have them. However, questionnaires to seek feedback from people were designed with pictures to help people understand the questions. We also saw complaints procedures were in large print and included pictures and symbols to make the information clearer.
● At the last inspection we saw a person whose first language was not English was struggling to communicate. At this inspection we saw efforts had been made to ensure staff could speak a person's language. Some staff who could not speak the person's first language had made efforts to learn some key phrases to help them communicate with the person.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At the last inspection the provider had not made every reasonable effort to meet people's preferences regarding their hobbies and interests. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 9.

●The provider had made improvements to the support offered to people to enable them to participate in hobbies and interests which they enjoyed. At the last inspection people told us they were bored and there was nothing for them to do. At this inspection one person told us there was not much going on, everyone else we spoke with said they enjoyed the events and activities which were on offer. One person said, "I like whatever they are doing for activities."
● The lounge areas of the home were open plan. This made the rooms airy and spacious but made it difficult to partition space for people. We saw a TV in one part of the home could be heard in another part where people were singing or listening to music. The provider told us they were giving some thought to how they could address this issue.
● The provider had taken steps to recruit additional staff devoted to spending time with people and helping them engage in activities they enjoyed.
● There had been a meeting with people to discuss what they would like to do, and more meetings were planned. People told us they spent time doing things they enjoyed. We saw people taking part in quizzes and singing.

Improving care quality in response to complaints or concerns
● We saw one example where a relative had raised a complaint and there was little documentation to show what had been done to consider the concerns raised. We spoke with the manager about this who told us they would look again at the concerns raised and investigate them.
● We saw each person had a copy of the complaint's procedure in their room in a format which was easy to read.
● People and relatives told us they knew how to raise a complaint. Some said they had had minor concerns which staff had responded to effectively. One relative told us, "When we have brought up any concern it has

been dealt with politely and efficiently."

End of life care and support

● At the time of the inspection, no one living at the service was receiving end of life care.

● Care staff had not received training to support people with end-of-life care. The manager advised they had approached a local hospice to seek training for the staff.

● People's end of life wishes were not always detailed in their care plans. This meant there was a risk their wishes and preferences may not be met by the provider.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection the provider had failed to implement robust audits and monitoring systems. This was a breach of regulation 17 (Good Governance) 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 17.

- The provider had established systems, but they had not always enabled the management team to effectively monitor and improve the safety and quality of people's care. The provider had not identified some of the issues we found during inspection. For example, ineffective recording of incident and accidents, failure to identify safeguarding concerns and lack of staff training in some key areas.
- Quality assurance checks had failed to identify that incident and accident processes were not always being followed effectively. For example, we saw when 1 person had been injured during care, there was no evidence of a detailed investigation. The local authority's safeguarding team had not been notified and there was no clear documentation of what steps had been taken to mitigate further risk. This meant this person had not been protected from further possible risk.
- Risk monitoring systems had failed to ensure the risks to 1 person being able to access the stairwell on an upper floor had been fully considered. This had left the person at risk of avoidable harm.
- Checks of the environment had failed to identify some of the repairs to walls had been of poor quality and needed further work to make surfaces easy to clean. This meant some walls posed an infection risk to people.
- Quality assurance systems had failed to enable the management team to ensure staff had a good understanding of MCA and DoLS and what this meant for people. This meant there was a continued risk people may not have their rights under the MCA protected.
- The provider had failed to remain up to date with changes in regulation. They were not aware of the need to provide all staff with training to support people with learning disabilities. This training had not been provided. This meant the person was at risk of inappropriate or ineffective support from staff as staff lacked insight into their needs.

The provider had failed to implement robust audits and monitoring systems. This was a continued breach of

regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our last inspection we found environment checks had failed to identify significant fire safety concerns. At this inspection these concerns had been addressed and staff had the equipment and knowledge to support people safely in the event of a fire. Systems had been established to ensure fire safety standards could be maintained.
● At our last inspection medicines management systems had failed to identify several concerns regarding how people were supported to take their medicines. At this inspection we saw systems had been established which allowed management to ensure people received their medicines safely.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people
● The provider had taken steps towards developing a more person-centred culture, however more work was needed. People had been consulted about the service they received and how it could be improved. People and their relatives had in some cases participated in reviews of their care. However, this had not yet resulted in care plans which reflected fully people's needs preferences and wishes. For example, around end of life wishes, cultural and spiritual needs there was sometimes very little guidance for staff.
● Quality assurance systems had been introduced and developed to help ensure better outcomes for people. However, as they had failed to identify some key risks of potential neglect or abuse, they could not be relied upon to ensure good outcomes for people.
● People and relatives spoke positively about the changes they had seen within the service in the last few months. They told us they felt the leadership of the home had improved the quality-of-care people were receiving. One relative told us, "The home is more homely than it used to be. The atmosphere is good, warm, caring and friendly." Another relative told us, "[The provider] is very good and friendly. He comes around quite often, and we have a chat… he is very nice and approachable."
● Staff told us they felt more supported by the new management team and the new manager. One staff member told us, "The manager is very good… [she] works very hard to keep the home up and [the deputy manager] works tirelessly."

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
● We were not assured the provider was fully meeting their duty of candour responsibilities. We found some incidents had not been fully investigated or shared with other appropriate professionals. This meant opportunities to take responsibility for mistakes and apologise could have been missed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
●Efforts had begun to engage people and their relatives and the staff in planning how the service was provided. Meetings had been held for staff and for people and more were planned with dates advertised in advance. Demonstrations of changes which had occurred because of people's feedback were seen in the types of activities planned and the meal options available to them.
● We saw evidence of the service working with other agencies and services to provide care for people when they needed it. For example, the management team had worked with west midlands fire service to ensure the staff team had a good understanding of how to respond in the event of a fire.
● We spoke with a professional who worked alongside with service regularly. They told us, "Communication is good… you can see the improvements in the home."