Highcliffe House Limited

Highcliffe House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 25 and 26 April 2018 and was unannounced.

Since the last inspection in March 2017 we have prosecuted the registered provider and registered manager (who is also a Director of Highcliffe House Ltd) for an offence under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12(1) refers to failure to provide safe care or treatment resulting in avoidable harm to person using a service, or exposes a service user to a significant risk of exposure to avoidable harm. A person fell from a window at the service and died. The registered provider and registered manager pleaded guilty and were fined at Magistrates court in January 2018. Immediately after the incident in 2016 we took urgent action to safeguard others using the service including ensuring window restrictors were fitted through-out the service. The 2014 Regulations make it a criminal offence to fail to comply with Regulation 12(1) where the failure to provide safe care or treatment results in avoidable harm to a service user or exposes a service user to a significant risk of exposure to avoidable harm. The 2014 Regulations took effect on 01 April 2015 and coincided with a transfer of enforcement responsibility for health and safety incidents in the health and social care sector from the Health and Safety Executive and local authorities to CQC.

The last inspection of Highcliffe House in March 2017 found that improvements had been made and the rating increased from Inadequate to Requires Improvement. However, there were still breaches in regulation and concerns about the overall governance and quality assurance.

Highcliffe House Nursing Home is a 30-bedded residential and nursing care service providing care, treatment and support, including end of life and care and support for people living with dementia. On the day of our inspection there were 23 people living at the service.

There was a registered manager who was also a Director of the registered provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection, we found a lack of consistency in the way the service was managed. The leadership, governance arrangements and culture in the service did not always support the delivery of high quality care. There remained an inconsistent approach to reporting and (where appropriate) investigating of incidents and safeguards. This was identified at our previous inspection and continues to place people's safety, health and welfare at risk. It also means there continues to be missed opportunities to improve care and mitigate risks.

This included continued lack of action following the death of the person who fell from a window. There had been no formal debrief, learning or review of what went wrong from the provider. It is important those

affected by such incidents, such as friends, family and others are informed of the actions taken to improve practice and reduce the risk of such events happening again. The Nominated Individual representing the provider stated they would now be implementing an internal investigation. We also identified the provider and registered manager had not adhered to their responsibilities under Duty of Candour. They had not formally written to the person's relevant representative, providing an explanation or apology for the incident. This did not demonstrate caring values, behaviours and transparency regardless of the outcome of the prosecution.

At our previous inspection in March 2017 we identified risks in relation to people's continence management, dehydration and pressure wound care. Whilst we found improvements to manage the risks to people in these areas, we found further risks to people that had not been identified and managed to keep them safe. This included choking, further environmental risks including unlocked doors intended to be locked to protect people from the risk of harm from unsupervised access.

Staff had received a variety of training relevant to their roles, however they remained unclear of the strategies in place to support people whose behaviour can be challenging. Staff lacked understanding about how to recognise when restraint of any form was being used and escalate if it was not appropriate or thoroughly assessed.

We continued to receive concerns about the numbers and quality of staffing and management. The registered manager could demonstrate action taken to manage employment issues, specifically around bullying and poor performance when it was reported to them. Despite this, concerns remained about bullying and blame culture in the service. The provider had not explored the reasons why this continued to be an issue to effectively address and identify the root causes.

The volume of information in people's care plans made it difficult for staff to access information in relation to people's specific care needs. Missing/incomplete information and inconsistencies continued to place people at risk of not receiving the care they needed. We have made a recommendation about improving care plans to ensure information about people's needs is easily accessible and up to date.

Despite these concerns people were positive about the care and support they received and that there were enough staff. We saw staff were intuitively kind, caring and compassionate towards people who lived in the service. Staff had developed good relationships with people.

People were supported to eat and drink according to their dietary needs, choices and preferences. People were supported to access ongoing healthcare support and significant improvements had been made to promoting healing of pressure wounds. Systems were in place to prevent the risk of cross infection, but on occasions essential elements of cleaning were missed. People were positive about the decoration and design of the premises, they liked living there because it was comfortable, felt like home and not clinical. People were protected from isolation and were involved in a range of activities that reflected previous lifestyles and current interests, including access to the local community.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration

or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will act to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Systems in place to assess and respond to risk, were not consistently applied or managed to protect people from harm, or the risk of harm occurring.

The right actions were not always taken to report and investigate safeguarding concerns.

Systems in place for the prevention and control of infection to protect people using the service from the risk of infections were not always effective.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Although staff had good access to training to ensure they have the skills and knowledge to carry out their roles and meet people's needs, learning had not been applied consistently where people behaved in ways that were challenging to others. Staff were not clear of strategies to manage these situations in a positive way.

Where restraint was used to provide personal care, best interest decisions had not been made or recorded.

People were happy with the meals provided and were provided with enough to eat to maintain a balanced diet.

People received support to access appropriate healthcare services.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were intuitively caring but this was not reflected in the providers overall approach and responses to incidents.

People were supported to make choices and decide how they

spent their day.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not always up to date and did not always contain sufficient information to guide staff on how to meet people's current care and nursing needs.

Systems were in place to listen and respond to people's concerns but none had been recorded since 2016

Is the service well-led?

Inadequate

The service was not well led.

The leadership, governance arrangements and culture in the service did not support the delivery of high quality care. This included not adhering to responsibilities under Duty of Candour.

Governance systems had not identified ongoing risks to people. Where things had gone wrong in the service, there was no evidence of lessons learnt and reflection on how to prevent such incidents happening again.

Attitudes and relationships between some staff had caused conflict amongst the staff team and resulted in bullying and a blame culture in the service.

Highcliffe House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 26 April 2018 and was unannounced. On the first day of the inspection the team consisted of two inspectors and a specialist professional advisor in nursing care for older people. The second day of the inspection was completed by two inspectors.

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

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

We spoke with eight people who were able to express their views, but not everyone chose to or were able to communicate effectively or articulately with us. 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.

We spoke with six relatives of people living at the service, six members of staff, the clinical lead and activities

organiser. We reviewed six people's care plans. We also looked at a sample of the service's quality assurance systems, the registered provider's arrangements for managing medication, staff training records, staff duty rotas and complaints records.

Inadequate

Is the service safe?

Our findings

Since the last inspection in March 2017 the registered provider and registered manager (who is also a Director of Highcliffe House Ltd) were prosecuted for an offence under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12(1) refers to failure to provide safe care or treatment resulting in avoidable harm to person using a service, or exposes a service user to a significant risk of exposure to avoidable harm. A person fell from a window at the service and died the registered provider and registered manager pleaded guilty and were fined at Magistrates court in January 2018. Immediately after the incident in 2016 we took urgent action to safeguard others using the service including action on ensuring window restrictors were fitted throughout the service. The provider could demonstrate this action had been taken to mitigate any further risk for others.

At this inspection the approach to health and safety matters was inconsistent. Radiator covers had been fitted to protect from scalds/burns and mesh bed rails (where people needed them) had been purchased to prevent the risk of entrapment. Personalised emergency information relating to evacuation or reaching a place of safety had been completed. Routine checks of systems, utilities and equipment were being made to ensure they were in safe working order. However these were matters brought to the attention of the provider by external professionals and via inspections. The provider was unable to demonstrate a robust system for recognising, proactively identifying and managing risks. For example, internal doors that had signage to say, 'keep locked shut' for people's safety, were unlocked. Both the door through the kitchen area leading down a steep staircase to the cellar and the Control of Substances Hazardous to Health (COSHH) cupboard were unlocked. The risk of people accessing the stairs and/or the COSHH materials had not been fully understood. There were 11 bottles of liquid paracetamol and five bottles of senokot liquid. Others contained lactulose syrup, ferrous sulphate and amitriptyline. The clinical lead told us these were normally emptied and rinsed out but agreed that in this case it had not happened. The clinical lead stated that all doors, were locked "when they have wanderers." Some people using the service are living with dementia and could be at risk of accessing the stairs and falling and/or taking medication not prescribed for them. Staff did not have continuous sight of people who moved independently around the building so would not necessarily be able to intervene to protect them from these hazards.

People's care records did not always reflect the current risks to their safety and wellbeing. For example, medicine had been prescribed for a person with Parkinson's Disease to aid their swallowing reflex making it safer to eat meals due to risks of choking. A member of staff confirmed the diagnosis of Parkinson's was made in November 2017, but no care plan or risk assessment for choking had been completed. Without these assessments in place the provider was unable to demonstrate how staff know about the risks, how to minimise them and/or what to do if the person deteriorates further.

A review of incident records and discussion with people, their relatives and staff confirmed there had been no choking incidents at the service. However, the failure to properly assess the risk and provide staff with the guidance they needed did demonstrate that all reasonable steps were being taken to minimise and respond to the risk.

Where falls had occurred, staff had not followed the advice in falls risk assessments, such as making a referral to the falls team or GP to review the persons medication. One accident record showed a person had six slips, trips or falls between 6 January to 28 March 2018. One of these falls resulted from the person climbing over their bed rails and they were found on the floor. The injury sustained was described as 'hitting head'. Two other incident reports also referred to head injuries, and one was recorded on a body map as laceration to the back of the head. There was no information to reflect this person had been checked by professionals in case they had concussion. Oversight of this had failed to identify the reoccurrence of falls, or the actions required to prevent further falls.

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

There was an inconsistent approach to safeguarding people, which sometimes put their safety, health and wellbeing at risk. For example, one relative told us, "The care is all right, but my [Person] hits out at staff when they provide their care, and as a result often has bruises, but they do bruise very easily." Care records and incident reports noted three incidents had been completed reflecting bruising. No investigation had been carried out to ascertain why the bruising had occurred, or what actions were required to minimise the risk of further bruising. The third incident report stated the person sustained a bruise during personal care. This had been referred as a safeguarding concern to the local authority for investigation. This inconsistency to investigate incidents where people had sustained injuries was identified at our previous inspection in March 2017. Conversations with staff and incident reports reflected there was a focus on the injuries to staff, rather than understanding and reducing the reasons for a person becoming aggressive. For example, a member of staff told us, "One person spits and pinches us when we try to provide personal care." Incident reports contained statements, such as 'lashed out at staff' and 'very aggressive during personal care, shouting/lashing out and dug nails into staff, and said hope that hurts'. Without a robust approach to this, opportunity may be missed to reduce incidents and identify any potential abuse or improper treatment.

Staff had varied understanding of safeguarding concerns and when these should be raised. The clinical lead failed to refer a safeguarding concern when a person was admitted to the service from hospital where they had developed a grade four pressure ulcer. This type of wound means there is significant damage to the surrounding skin, often exposing bone, tendon or muscle. They told us they had not raised a safeguard alert as they were concerned this would affect commissioning with the hospital and future discharges to the service. The inconsistent approach to managing safeguarding concerns, was identified at our previous inspection in March 2017 and continued to place people's safety, health and wellbeing at risk.

This demonstrated a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The leadership team were unable to demonstrate how they proactively learned from incidents within the service. Although some support had been offered to staff there was no system or process in place for shared learning and improvement based on things that were happening in the service. For example, although staff were aware window restrictors were being fitted to prevent other falls, there had been no discussion about why this risk had not been identified, nor how staff could be part of recognising and escalating similar concerns in the future.

Some individual risks to people, such as incontinence, dehydration or developing pressure wounds had been assessed and management plans were in place to minimise the risk of harm. These provided guidance to staff to help people stay safe, including regular monitoring, repositioning and application of creams. This approach needed to be consistently in place for all people and all risks.

At our previous inspection in March 2017 people gave mixed views regarding the numbers of staff available to meet their needs. In addition, information had been received since sharing concerns anonymously about staffing numbers and skills. At this inspection, we again received mixed feedback from people, their relatives and staff, about staffing levels. We also received further anonymous concerns about the service being understaffed, people being assisted up early in the morning and being assisted back to bed early in the afternoon. Concerns were also raised that staff were under pressure and do not have time to provide the support people need. We considered all these matters during this inspection and again found inconsistencies and varied views. People were having their basic care needs met, however as these issues continue to be raised we were not assured the provider has taken a proactive approach to demonstrating this to all stakeholders. There was some recognition about the impact of staff skill mix and deployment but no information around how this might be addressed to improve things.

Rotas over a three-week period from 07 April to 29 April 2018 showed the number of staff matched those as described by the clinical lead and all staff spoken with. They all confirmed these reflected the normal staffing ratio, of a nurse, a senior or team leader, a senior health practitioner and four care staff. The nurse on duty told us there was sufficient staff available to meet people's needs, however said some days run more smoothly than others. They put this down to the skill mix of staff, rather than numbers and commented, "Some staff have get up and go and work hard, others need constant prompting. It's the quality of the carers, not quantity, that count."

People's comments, included, "Biggest problem is lack of staff", "There are long periods of time where I see nobody, it's the same excuse every time, we are short staffed" and "Sometimes not enough staff." One person told us, "Staff, I have my ups and downs, some staff say I am too demanding, but that's because they lack staffing." When we asked the person if they were able to give examples of how a lack of staff had impacted on them, they commented, "No, that's what staff say." One relative told us, "Every relative has concerns about staffing levels", however they could not give any examples of how this had impacted on their [Person's] care or others. Another relative told us, "Staff do not always have enough time to sit with them, so I come in every day and help them with their lunch".

Comments from staff included, "Staffing levels are okay, but we could always do with another member of staff. Two care staff are allocated to each floor, we work in pairs to provide personal care and carry out manual handling, as most people require two staff to transfer," and "There are not enough staff at times to meet people's needs, we do have to rush, it can be difficult, it is a very demanding job. Nurses and the clinical lead do help when we are short staffed, they are very supportive and helpful." Another member of staff told us, "Of late quite a few staff have left, and we are covering extra shifts. We work as a team, so that people do always get the care they need."

People who could communicate with us, said they were able to get up and go to bed when they wanted. One person said, "I get up most days between 11 and 3 as my [Person] visits." Another person commented, "I can stay up till late if I want too." One relative told us, "My [Person] does receive the care they need, I was a bit worried at first, particularly first thing in the morning, as they tell me they have to wait; however, I am not sure of their [Person's] ability to measure time." One relative told us, "My [Person] does not get out of bed. They fractured their hip, before moving here and would not engage with physiotherapist, and lost their ability to walk. Staff did encourage them to get up for their birthday party, but they got up half an hour and then wanted to go back to bed."

The premises were generally clean and tidy, with no unpleasant odours, we found on occasion some essential elements of general cleaning to protect people from the risk of infection was not acceptable. For example, in the 'Residents' toilet on the ground floor the top and lid of the commode were clean but

underneath the seat was soiled with stale faeces. Additionally, in the clinical room we saw a metal trolley containing equipment to monitor peoples' observations, including blood pressure and temperature. The cleaning log for the equipment was last dated 16 April 2018. The clinical lead was unable to give a full account of the cleaning protocol and how often this should happen. Neither were they able to show any specific cleaning materials for carrying out this task. However, in contrast we saw good processes in place to minimise the risk of infection for a person with a Percutaneous Endoscopic Gastrostomy (PEG) feeding tube in situ. This is a tube which is passed directly into a person's stomach most commonly to provide a means of feeding when oral intake is not adequate, because of poor swallowing. The PEG requires irrigation with water prior to the persons feeding regime. We observed staff undertaking this procedure, in accordance with the instructions on the persons MAR chart, care and risk assessment.

The housekeeping coordinator showed us records to confirm that a deep clean of people's rooms was carried out monthly, including carpets, beds and bedframes. They told us one room was done thoroughly every day. They coordinated a monthly check on mattress and pumps, where used and if any were identified as broken, this was reported to maintenance. They told us housekeepers cleaned mattresses every day after the carers striped the beds, using sanitiser and deodoriser and left the bed to air before being remade. Additionally, as an extra control measure to prevent the spread of infection they told us mattresses were sent to a company, used by the provider on a rota basis, for decontamination. This included cleaning all tubing and pumps, servicing and cleaning.

Our previous inspection found the provider followed safe recruitment practices, with steps taken to assess that staff employed were of good character, competent and had the necessary skills for the work they were employed to perform. Staff spoken with confirmed they were unable to start employment until their Disclosure and Barring Service (DBS) check and references were obtained. The DBS helps employers to make safer recruitment decisions by providing information to establish if a potential employee has a criminal record and whether they are barred from working in adult social care settings. Registered nurse pin numbers were being monitored monthly with National Midwifery Council (NMC) to ensure nurses were fit to practice.

People told us they received their medicines when they needed them. Where people chose to and were assessed as able to administer their own medicines this was respected and plans were in place to support them. Random sampling of people's medicines, including controlled drugs against their Medication Administration Records (MAR) charts confirmed people were receiving their prescribed medicines. The controlled drug record book had been signed by two staff and the stock of people's medicines matched what was recorded. Where people had been prescribed PRN (as necessary) medicines, such as analgesia for pain relief, specific plans were in place, including the details of the medicines and how to administer it. The clinical lead told us peoples medicines were administered at times that best suited them. However, as referred to above, we found one person's PRN pain relief was not offered prior to providing personal care as stipulated in their care plan. A 'Resident Preferred Medication Chart' had been implemented stating whether people preferred their medicines, before or after their meal. We checked the MAR charts as we were concerned that people were not receiving their medicines at the times specified in the prescribing instructions by their GP. We found no evidence to suggest there were any errors or omissions in respect of timing of people's medicines being administered. This was confirmed in discussion with a relative, who commented, "Staff ensure residents take their medicines, as needed."

We observed a nurse completing the lunchtime medicine round. The nurse was patient and interacted in with people in a positive way. For example, they took time to explain what the medicine was for, gave people a drink of their choosing and gave them their tablets one at a time.

Requires Improvement

Is the service effective?

Our findings

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We saw appropriate DoLS authorisations were in place to lawfully deprive people of their liberty for their own safety, where they were unsafe to leave the building alone. Improvements were needed so that staff recognised all forms of restraint. For example staff were unclear as to what was legal or unlawful. One member of staff told us, "I do just about understand what is lawful, I use enough force to stay safe." Another described laying a towel over a person's hands during personal care to stop them lashing out and did not see this as a form of restraint. This had not been recorded in their care plan or risk assessment to ensure support was provided in a consistent way and was appropriate. Without this the staff were unable to demonstrate that their approach had been fully considered and was in the best interests of the person when they lacked capacity to make an informed choice.

Staff told us training was delivered via a mixture of classroom based sessions or eLearning. Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and end of life training was being delivered to a group of staff on the first day of the inspection. On the second day, staff attended a session on enteral feeding. One member of staff commented, "I have received a lot of training, I have done all the mandatory training, including MCA and DoLS, and life support including choking and Cardiopulmonary resuscitation (CPR). Another member of staff told us they had recently attended a refresher in manual handling training and had attended a 'sling' workshop. This had enabled them to assess people's moving and handling risks. We reviewed the moving and handling assessments in peoples care plans and noted these contained detailed guidance for staff and clearly explained the action staff needed to take to safely move and reposition people.

Staff were provided with opportunities for their learning and development. The clinical lead told us in last 12 months, senior staff had been supported to develop their role. This included training and support to administer medication, run the shift, conduct audits, attend to people's specific needs, and provide support to team leaders, as required. One senior had also completed training making them a qualified Phlebotomist. [A phlebotomist, can take blood samples from people so that they can be examined in a laboratory and the results are used to diagnose diseases and conditions.] Additionally, both the clinical lead and the registered nurse on duty confirmed they had access to training to support their continuing professional development (CPD) to retain their nursing registration. The nurse told us, "I have attended training at a local hospice to keep my nursing knowledge up to date. I have recently completed training in wound care, and I have registered to attend verification of death." The registered manager and provider had not considered how to demonstrate this approach impacted positively for those using the service, for example by reducing reliance on external health professionals, speeding up diagnosis and changes of care.

We spoke with a new member of staff who told us they felt supported and had met with their supervisor to discuss how they were getting on in their role, working with staff and the team. Staff told us they received regular supervision. The clinical lead showed us a supervision template. This gave a list of 27 suggested

topics for discussion, which included, but not limited to training and development needs, clinical governance, polices and protocols. Staff were encouraged to pick two topics each supervision and the supervisor would pick two to ensure all topics were covered over the course of the year.

We observed people eating their midday meal. People ate their meals where they chose, either in the dining / lounge area, conservatory or in their rooms. The mealtime was seen to be a positive experience for people with a good ratio of staff and relatives present to ensure they received the support they needed to eat their meal. People told us the, "Food is good" and "I enjoy the food." One relative told us, "Food is reasonable. The catering staff are very friendly; they offer other visitor's drinks and me as well." Another relative commented, "My [Person] is not eating very well. Their ability to feed themselves has deteriorated, their arm is not working well, and their swallowing and chewing has deteriorated. The vegetables can be quite hard, I need to mash them up, and chop up the meat very small due to [Person] being at risk of choking. They still like to eat toast, but staff cut the crusts off. Staff are doing their best."

We saw staff gave people choice about meals by describing the options available to help them to decide about what they wanted to eat. For example, the kitchen assistant told us, "I ask people about their choices, what they want and wait for their response, if I can't understand I will write it down. I have a list of people's likes and dislikes to act as a prompt to help them make choices." We observed this member of staff discuss lunch options with a person in their room. They knew the persons dietary needs well and encouraged them to make a healthy option, as they often refused what was on the menu. They discussed having an alternative of a 'nice piece of smoked haddock' with some vegetables, to which the person agreed. Staff and the kitchen assistant spoken with had a good knowledge of people's dietary needs, who was diabetic and who needed thickened fluids, soft diets etc due to choking risks. The kitchen assistant told us they had written information in the kitchen as to who was at risk, and that the cook (catering manager) informed them when there were any changes in people's dietary needs.

The clinical lead provided examples where working with professionals had improved people's health and wellbeing. One person admitted to the service had been very poorly. However, because of regular care and input from the GP, their health had improved and they were no longer considered to be nearing the end of their life. Another person came to the service from hospital following a diabetic hypoglycaemic episode where their blood sugar levels had dropped below normal range. They had developed a leg ulcer and doctors had advised their leg needed to be amputated. However, since they have been at the service and having their wound dressed on a regular basis it had healed. Photographs in the person care plan confirmed this improvement and the positive impact on the person's health and wellbeing.

Staff worked closely with healthcare services, such as occupational therapists, dieticians, Parkinson's consultant and tissue viability nurses. People's records confirmed this however, as previously identified in the Safe section of this report, advice from health professionals had not consistently been actioned. For example, one person with swallowing difficulties linked to their condition had been seen by the Speech And Language Therapy team who recommended a category D diet, and stage 1 thickened fluids. Their catering plan, did not reflect this level of detail, it just stated 'soft diet.' This placed the person at risk of choking, if staff unfamiliar with their needs gave them a drink without the thickening agent. Systems were not in place to demonstrate how this could be avoided as far as possible.

People told us they were supported to maintain their health. The clinical lead told us, weekly clinics were held with the practice nurse from the GP surgery to ensure people's concerns about their health were discussed and dealt with promptly. Entries in people's health records also confirmed that the GP visited the service, to see people whenever this was needed. A relative told us their [Person] had been admitted to the service from hospital with a grade four pressure ulcer. "Staff are good at keeping a check on their skin to

ensure no further pressure wounds develop. I feel [Person] is getting good care here, things are improving, the clinical lead has done a good job at reducing the infection in their wounds and they are healing." The same relative told us, "I have a good dialogue with the clinical lead, manager and nurses. I do feel that I am kept informed about [Person's] health and wellbeing."

The facilities and premises were designed in a way that were accessible to people using the service. The environment was generally well maintained, communal areas and bedrooms were warm, decorated and homely. Outside each person's room there were photographs of the person's family, their loved ones, and their own pictures. These were useful in helping people remember where their rooms were. Large signs were fixed to doors to help people distinguish between bathrooms and toilets. One relative told us, "Bearing in mind this is a nursing home, it doesn't feel clinical, in fact compared to my previous experiences of care homes, this has a friendlier atmosphere." Another relative commented, "Highcliffe has plusses and minuses. The location and interior are important factors. I and the family can easily visit. There are places myself and family members can go when we visit, for example, a walk along the sea front, cafes etc. I also like that the home has various rooms we can use, such as the lounge, conservatory and quiet room."

Requires Improvement

Is the service caring?

Our findings

The provider was unable to demonstrate a consistent overall approach to ensuring the service is caring in all aspects of its care provision. This links with the overall leadership and culture of the service as described in Well Led. When we spoke with people using the service, family, friends and other professionals they described staff who were intuitively caring and their intentions to provide good care were not in question. They were not aware of the concerns being raised in relation to poor staff to staff relations, culture, bullying and derogatory terms used in some records. Their experience of the care was drawn from their own observations.

Staff shared with us some examples of difficult staff dynamics in the service but were clear this did not impact on their approach to providing care. One member of staff told us, "I always aim to treat people with respect, if someone is upset I will sit with them and try to cheer them up." Staff were courteous and professional towards people and their families. One member of staff told us "I always ensure I knock on peoples' doors before entering and ensure their door is shut when I provide personal care."

We saw positive interactions between staff and the people they supported. Staff were smiling and using humour as they engaged with people. They were friendly, affectionate and showed concern for people's wellbeing. One member of staff told us, "We treat everyone that way." Another commented, "I think we [Staff] are very caring to people. We make sure they are happy. I do try to sit and talk with people, and comfort them if they are upset." Despite this there were significant inconsistencies in the experiences of some people. For example a relative told us, "My [Person] say's they feel like a queen here. It is an amazing home. I am here nearly every day. At first, I was here every day, but now two to three times a week. It is so comforting to know my [Person] is looked after. I visited other homes in Felixstowe before coming here, this is a welcoming home, I can visit whenever I like." Another relative told us they had to point out small things, before staff took any action, such as when their [Person's] wheelchair needed cleaning. They commented, "I often find [person] with food down their jumper and on the floor around where they are sitting". They did not feel this was how the person wanted to look but this had not been explored to help the person stay clean and if this was what they wanted.

A pre- admission checklist had been implemented which was helping to ensure enough information was available so staff could provide the right care when people moved in. The clinical lead told us people and their next of kin were involved in these discussions to ensure relevant information about their current care needs, their past, their preferences, and the people who important to them, was obtained. Relatives spoken with confirmed they and their family member were involved in planning and making decisions about care.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in March 2017 we identified staff did not always have the information they would reasonably need to provide care to people, specifically in relation to wound care, repositioning and pacemakers. The clinical lead told us they had carried out a review of all people's care plans. NHS referencing guidelines for staff caring for people with complex needs, such as Parkinson's, diabetes, and pacemaker implants had been included in the care plans. We also found best practice guidance links had been imbedded into the care plans for nursing staff to reference, for example, 'Good practice in health care incontinence Urostomy European Association of Urology' and 'Older people and independence and mental wellbeing NICE guidance.'

People's wellbeing charts reflected they were receiving appropriate care, including adequate hydration, regular repositioning and continence checks. This was also confirmed in discussion with a relative who told us, "My [Person's] needs are being met, including regular repositioning. They have plenty to drink, they always have a coffee on the go, and biscuits and they eat them all." Where people had chosen to stay in bed they had been provided with personal care and looked comfortable.

Despite these improvements information was still inconsistent. For example, a person who moved to the service in January 2018 had little further information other than their initial assessment had been completed. Other than a moving and handling and their diet there were no care plans or risk assessments to guide staff on how to provide their care. Where people's needs had changed these had not always been reflected in their care plan. For example, one person's dependency assessment reviewed in February 2018 referred to them as having a long-term catheter, however their continence assessment did not reflect this. When we checked with the person they confirmed they did not have a catheter. Another person's Medicine Administration Record chart showed their pain relief was stopped in February 2018, however their pain management plan still referred to their use.

Care records were made up of a set of standardised paperwork that were not always relevant for every person. For example, people without a diagnosis of dementia had a 'clinical dementia rating tool' contained within their care records. There was no reason for this to be included and added to the volume of paperwork contained within the care plans. Nursing plans duplicated some of the same information held in the care plan. Staff told us it was hard to navigate and find out about a person's individual needs. Comments included "You can't always find information when you are in a hurry, for example, if a person is being admitted to hospital," and "I read care plans now and again, if anyone is new I will read the overview and their background. I should look at them more but there is a lot of information." Care staff told us they did find the summary profile at the front of the care plan useful as a 'snap shot' for task based routines. The leadership team had not tested the system to ensure it worked effectively both for day to day information and when accurate and up to date information was needed promptly.

We recommend that the provider seeks advice and guidance from a reputable source, about personalised care, nursing and support planning.

Information from the provider stated concerns and complaints were used as part of driving improvement. However, there were no examples to demonstrate this. We looked at the complaints file and no complaints had been recorded since January 2016. We looked at the systems in place to respond to complaints and found the policy was out of date and had not been reviewed for its continued relevance since July 2016. Relatives told us they knew how to make a complaint if they needed to and were confident their concerns would be responded to. Comments included. "If I have had to raise concerns, I have raised them with the manager and clinical lead and they have been dealt with," and "I have no complaints, if I was unhappy about something I would have no problem raising concerns with the manager." Another relative commented, "I am not worried at all about anything, I am very happy with the care and support [Person] receives. If I have any niggles I only have to talk with staff and they are sorted." It is important to have oversight of all issues, to ensure effective oversight and opportunities are taken to learn and reduce reoccurrence for the person and/or others.

Our previous inspection found that where people had pressure wounds these were not being monitored effectively so that any progress or deterioration was identified and addressed. At this inspection we saw the clinical lead had been effective in promoting healing of people's wounds. This included photographs of the wounds to demonstrate how they were healing.

Systems were in place to protect people from social isolation. Examples included liaison with voluntary befriending services, such as those run by local church groups. The activities coordinator told us people, their relatives and staff were encouraged to participate in activities and a range of entertainment, for example coffee mornings and afternoon tea parties were a regular feature and were well attended. As were fish and chip days out by the sea, strawberry cream teas, fund raising for various charities and national and international sporting events. The activities coordinator told us although, most people using the service were English speaking, there was a recognition that several staff were from the European union. They told us they worked with these staff to organise a tea party from their country, for example, India and Romania for people to experience different cultures. This gave a positive opportunity to share and learn. There was also a film club, where people could watch a film of their choice.

People and their relatives told us they were involved in planning activities. One relative commented, "My [Person] was 101 years of age, and staff put on a 100th birthday party for them." Other comments included, "There's not really a daily routine, it depends on what's happening on the day" and "We have quizzes, bingo, never a dull moment." However, one relative told us, "Although, staff are friendly and do try to engage people in activities, I think these could be more varied. My [Person] used to do armchair exercises before they were admitted to hospital. They need to do exercises. Armchair exercises would be good. They do have input from physiotherapist, but it's not enough, but having said that they could not walk when discharged from hospital to Highcliffe, but they are now walking short distances, which is good. They have Parkinson's, and the GP told us, if don't use it, you lose it, so it is important they do the exercises."

People were supported to maintain relationships with those close to them. People were encouraged to hold family gatherings at the home, so that they could entertain their family and friends on special occasions. For example, one person on a yearly basis, thoroughly enjoyed being able to entertain their family in the conservatory, and will either ask the home to provide a buffet style meal or their family will bring in fish chips.

End of life policy and protocol had been implemented which reflected the National Institute of Clinical Excellence (NICE) quality standards for end of life care for adults. We saw end of life care planning, was discussed with people when they moved to the service, including what the person would like to happen in a time of crisis. People had been supported to complete an advance care plan which gave them the

opportunity to express any wishes for their end of life care and funeral arrangements. These were in date and had been discussed with their family members, if appropriate. As part of their end of life planning where it had been agreed people had a Do Not Attempt Resuscitation (DNAR) orders in place. A DNAR form is a document issued and signed by a doctor or medical professional authorised to do so, which tells the medical team not to attempt cardiopulmonary resuscitation (CPR).

At the time of our inspection, no one using the service was nearing the end of his or her life, and therefore we were unable to assess how this aspect of the service was managed. However, staff told us and records confirmed they had attended in depth end of life training to ensure they have the knowledge, skills and attitude to be competent to provide high quality care and support for people approaching their end of life and for their relatives.

Inadequate

Is the service well-led?

Our findings

At our previous inspections in May, July and August 2016, we found major concerns in relation to ineffective governance of the service. The service was rated as 'Inadequate' and placed into special measures and we used our powers of enforcement to place a condition on the provider's registration to stop them admitting further people to the service. We inspected the service again on 08 and 15 March 2017. With the support provided by the Local Authority and the Clinical Commissioning Group, improvements had been made. The overall rating changed to 'Requires Improvement'. There were still concerns about the oversight and governance arrangements and as a result we added conditions to the provider's registration to encourage improvement in this area.

At this inspection we looked at how the provider and registered manager had continued to address these issues. This included their response to being prosecuted when a person fell from a window at the service and died The provider and registered manager pleaded guilty and were fined at Magistrates court in January 2018. Legal process has restricted us reporting fully on this matter previously.

Minutes of a full staff meeting had taken place in August 2016, to update staff on the events following the death. However, the minutes did not state if there had been any discussion with staff about what went wrong or what could have been done differently. At this inspection staff told us they had been offered some support and time off, other staff working at the time of the incident had left the service. There had been no internal review since the conclusion of the prosecution in January 2018. The opportunity to learn from the incident and improve practices had not been explored. The Nominated Individual for the provider confirmed no internal investigations had taken place with regards to the incident at the time or since. They also confirmed no contact had been made with the person acting on behalf of the person who died, but on reflection they would now do this. Registered providers and registered managers are required to demonstrate 'Duty of Candour' to ensure openness and transparency with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. There are some specific requirements that providers must follow when things go wrong, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. This can also help them to know that others will not be exposed to the same risk in the future or it will be minimized as far as possible. It is of serious concern that the provider and registered manager have not demonstrated 'Duty of Candour' throughout the case.

This demonstrated a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection there continued to be shortfalls which impacted on the quality of care provided. The leadership team did not have effective oversight to assure themselves people receive high quality care and if they did not, what improvements could be made, by when, by whom and who had overall responsibility. This was either because of a lack of staff recognition/understanding of the care needed, proper implementation and/or lack of effective oversight/management. This included failure to fully report and investigate safeguarding concerns, ensure risks were identified and acted on such as choking,

environmental risks for access to stairs, chemicals and medicines and adhere to responsibilities under Duty of Candour. The service provides care to elderly vulnerable people, some of whom live with dementia. Whilst staff acted to mitigate the risks we identified at the time of our inspection, we remain concerned that the provider and registered manager have not been able demonstrate this regulation being consistently met over the past two years. In addition, given the recent prosecution, the learning has not been used to support improvement across the whole service.

Providers are expected to continually evaluate and seek to improve their governance and auditing practice independently without the need for intervention from stakeholders or the CQC. Information provided by the registered manager stated they worked in partnership with other agencies to keep up to date with best practice and guidance. This included, checking the CQC website and monthly newsletter, as well as other organisations, such as the NHS & SCC website for any updates regarding best practice. However, it is not clear how this information was used to ensure quality and/or improve the service. The breaches of regulation in this report demonstrate shortfalls which do not reflect effective implementation of best practice, guidance and or regulations designed to improve quality and safety for people.

Information received from the provider stated they encourage and deliver an open, fair, transparent and supportive culture at all levels. However, since the last inspection in March 2017 we had received intelligence regularly raising concerns in this area. The provider's oversight was not looking at how to tackle this situation as part of the quality assurance processes, including how this might impact (knowingly or not) on the quality of the experience for people using the service.

Comments included ongoing concerns about poor management including, '…(management) doesn't care about staff, they talk down to staff' and 'covers things up' and "I do not feel that the registered manager is strong enough; they are very nice, but not a strong leader, but the buck stops with them." However, other comments were more positive stating "I feel supported by the clinical lead and manager, if I have a problem, they would help." Another said, "The manager is approachable and supportive."

We observed conflicts between staff relating to attitude, poor relationships and peer support. Some staff used a tone of voice, language and actions which did not promote a positive team culture and some staff also told us of a 'bullying and blame culture' within the service. Despite this they all told us their priority was the people they provided care for.

This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they took bullying extremely seriously and operated a 'zero tolerance' approach. They showed us investigations into concerns raised about staff. The outcome confirmed 'intimidation and bullying behaviours' had been displayed by all those involved. All staff concerned were reminded of the bullying and harassment policy and any further incidents would be dealt with under disciplinary procedures. The records of investigations showed these had been completed in consultation with the providers human resources department to ensure they were carried out in line with employment law.

Despite the mixture of comments some staff shared their positive experience of working in the service. This included "Overall, I think this is a kind and caring home. It is a homely and happy place. There is normally laughter with residents, it's a nice place and has a nice atmosphere. There is a good rapport with people and their relatives. It doesn't feel like a nursing home. The residents come first, their needs not the staffs. As it is a small home, I usually know what is going on, communication is good, I can speak with registered manger

directly, if need to." Another commented, "I have worked here for a long time and I have seen a lot of changes, with regards to staffing and the people living in home. It's the staff that make the home, we are a good staff team, we get on with the job the best we can, we are all on the same wave length."

They had established good links with the local hospice team to keep up dated with current practice in relation to palliative and end of life care. The registered manager had also engaged with 'My home life'; programme. This is an initiative run by the local authority to support registered managers to promote people's quality of life and deliver positive change in care homes for older people. This enabled the registered manager to meet with other managers and share best practice. Additionally, the provider was in the process of being assessed for re - accreditation of the Investors in People Award. Investors in People is a recognition that an organisation looks to improve performance and realise objectives through the management and development of its people.