Highcliffe House Limited

Highcliffe House 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?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on the 3 May 2016 and was unannounced.

Highcliffe House Nursing Home is a 30 bed 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 27people living at the service.

There was a registered manager who was also 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. However, as this is a care home with nursing we found that there was no clinical lead with overall responsibility for clinical governance of the service.

The provider's medicines management policy which provided staff with procedural guidance for ensuring the safe administration of people's medicines was brief in detail and failed to provide guidance to the level of detail required in line with current legislation including the National Institute for Clinical Excellence (NICE) guidance for managing medicines in care homes. There were shortfalls in the management of people's medicines. These had not been identified by the provider's medicine audits. This meant we could not be assured that people always received their medicines as prescribed.

There was a lack of regular, effective quality and safety monitoring of the service. The provider's audits were found to be sporadic, irregular and did not identify the shortfalls we found in relation to qualified nurses management of people's medicines and inadequate medicines management policy. There was no clear, established system of clinical governance in place and operated effectively with regularity which would ensure regular assessment and monitoring of risk in relation to the regulated activity which included nursing care.

The service was caring because people were treated with kindness, compassion and their rights to respect and dignity promoted.

People were provided with a variety of meals and supported to eat and drink sufficiently. Where support was required this was provided in a caring, respectful manner.

People's needs had been assessed prior to their moving into the service. Within care plans people's health care needs had been recorded and input from other healthcare professional described. However, further work was needed to ensure that care plans were reviewed and updated in a timely manner to reflect people's changing needs.

The service was found to be clean and well maintained. People's room were individual and people have

some of their own personal items making the rooms homely. There were systems in place to protect people from the risk of acquired infection.

People said that they were supported to voice any concerns they might have and the manager had been supportive in listening to suggestions they had made to improve the service.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the management of people's medicines. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe because there were shortfalls in the management of people's medicines and these had not been identified by the provider's medicine audits. This meant we could not be assured that people always received their medicines as prescribed.

Staff had been provided with training and demonstrated their understanding of how to identify people at risk of abuse and the procedure for reporting concerns.

People's likelihood of harm was reduced because risks to people's health, welfare and safety had been assessed and risk assessments produced to guide staff in how to mitigate these risks and keep people safe from harm.

The provider's recruitment procedures demonstrated that they operated safe and effective systems.

Is the service effective?

Good

The service was effective.

Staff and the manager understood their roles and responsibilities with regards to the Mental Capacity Act 2005.

People were supported to access ongoing healthcare support.

People were supported to eat and drink according to their dietary needs, choices, wishes and preferences. People's nutritional needs were assessed.

Is the service caring?

Good

The service was caring.

Staff were attentive and caring in their interactions with people.

People's privacy and dignity was promoted and respected. Staff took account of people's individual needs.

Wherever possible people were involved in making decisions

about their care and their relatives were appropriately involved.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plan summaries used to summarise the over plan of care, useful to guide new and agency staff were not always consistent with what was recorded in the person's overall plan of care. Care plans had not always been updated to reflect people's current care needs.

People said that they were supported to voice any concerns they might have and the manager had been supportive in listening to suggestions they had made to improve the service.

Is the service well-led?

Requires Improvement

The service was not sufficiently well led.

There was no clinical lead appointed to the service to monitor the standards of nursing care and provide regular clinical supervision for nursing staff.

There was a lack of regular, effective quality and safety monitoring of 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 the 3 May 2016 and was unannounced.

This inspection team consisted of one inspector, one specialist nursing advisor with specialist experience in mental health and general nursing and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience had experience of providing care and support for an older person.

We carried out observations of the interactions between staff and the people who lived at the service. Prior to our inspection we spoke with stakeholders including commissioners of services.
We reviewed information available to us about the service, such as statutory notifications. A notification is information about important events which the provider is required to send us by law.

We reviewed care records for six people who used the service. We also reviewed records in relation to medicines management, staff rotas, staff training matrix and other records related to the quality and safety monitoring of the service.

During our inspection we spoke with ten people who used the service, four relatives and seven staff including two nurses, the manager and a nurse consultant.

Requires Improvement

Is the service safe?

Our findings

Medication administration records (MAR) did not confirm that people were receiving their medicines as prescribed. When we compared medication records against quantities of medicines available for administration, alongside a nurse we found numerical discrepancies and gaps in records for the majority of the medicines we reviewed. This included a review of stock and records for the administration of anticoagulant medicine, Warfarin.

We found medicines that had been dispensed into administration pots and left in the medicines cabinet. Nursing staff had signed the MAR records for these medicines as administered when people had not received them.

One person's stock of medicines did not balance with the MAR records. Nursing staff told us this person had been admitted to hospital and that some of their medicines may have gone with them. However, records as required by law had not been maintained to evidence an audit trail that would evidence that medicines had been discharged from the service.

Where medicines had been prescribed for external administration such as barrier creams to protect people from acquiring pressure ulcers, we found gaps on the MAR records where staff should sign to confirm they had administered these medicines. This meant we could not be sure these people had received their medicines as prescribed.

Where charts were in place to record the application and removal of prescribed transdermal pain relieving skin patches, there were gaps in the records where staff had signed to say they had administered. However, nursing staff had not recorded where the skin patch had been placed on the body which would have evidenced that care had been taken to place the patch on alternate sites at each administration. This meant that we were unable to determine if staff had administered patches in accordance with the prescriber's instructions to ensure people's safety and effectiveness of the medicine.

Systems in place to check the balance of controlled drugs stock against records maintained within the controlled drugs record book were up to date and two staff signatures had been obtained at the point of administration. However, we found that there was a lack of audits and checks in place to balance all other medication stock against MAR records. Medication audits carried out by the manager were sporadic and had not identified the shortfalls we found at this inspection.

The provider's medicines management policy which provided staff with procedural guidance for ensuring the safe administration of people's medicines was brief in detail and failed to provide guidance to the level of detail required in line with current legislation and National Institute for Clinical Excellence (NICE) guidance for managing medicines in care homes.

This demonstrated a breach of Regulation 12(1)(2)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from a review of records and discussions with staff that they had been trained in recognising potential abuse and were able to demonstrate to us their understanding of what steps they should take to safeguard people from the risk of harm. Staff training provided staff with the required knowledge they needed to recognise the signs of abuse. They were aware of and understood the provider's whistleblowing policy for reporting concerns they might have. Staff told us they had confidence in the management of the service to take appropriate action in response to any safeguarding concerns they might have.

Comments we received from people with reference to the availability of staff to meet their care and treatment needs included, "It is ok here, I sometimes have to wait for the toilet. The longest was 30 minutes. They have to lift me and they are busy in the mornings between 7am to midday but average time I wait is about 10 to 15 minutes", "It is alright here. The staff call me darling and I like that, the staff are alright" and "I have a buzzer. They always come. The longest wait was 10 minutes. It's the same time night and day." One relative told us,
"My [relative] is safe here. The staff are caring. The previous home was not so good." Another told us, "There are good staff here there appears to be quite a lot of them and they keep [relative] nicely and they listen to me and do what I ask. I have not noticed any problems."

Staff and the manager told us that there had been recent staff vacancies which had required the use of agency staff to ensure sufficient staff were available. The manager told us that these vacant posts had now been filled and that there was now an improvement in the availability of staff to provide consistent safe care and treatment.

We observed people who were being cared for in bed had availability of a call bell and records had been maintained of regular staff visits to the person to monitor their health and welfare.

A range of assessment screening tools were used to identify risks to people's health, welfare and safety when supported by staff with mobilising. For example, people with limited mobility had their moving and handling needs risk assessed and a plan put in place to guide staff in safe manoeuvres. "One person told us, "The staff have to use a hoist to lift me. They put the straps on and tell me what is happening. There is always two of them and I feel safe."

The Malnourishment Universal Screening Tool (MUST) was used to identify individuals at risk of inadequate nutrition and losing weight and Waterlow risk assessments were undertaken to identify those at risk of pressure damage to their skin. Where risks such as skin integrity were identified, specialist mattresses and cushions were in place to reduce the likelihood of injury. Checks were undertaken to ensure air mattresses set at the correct level for people's weight.

Accidents and falls were recorded and analysed and the manager looked at a range of factors which may be a contributing factor. We saw that actions were put into place to reduce the risk of injury. These actions included the use of pressure mats to alert staff to the movement of people who had been assessed as at risk of falling. Referrals were also made to the falls prevention service for specialist advice and assessment where people had repeated falls. However, there was a lack of support for people who presented with distressed behaviour to situations or others staff referred to one person in daily records and in discussion with them as, 'aggressive' with little recognition of any risk assessment or care planning in place to identify triggers for this behaviour. Staff told us they had not received but would benefit from training in positive de-escalation techniques to support people appropriately and avoid the risk of harm to the person or others.

Health and safety audits were carried out by a designated member of staff. For example, in relation to water temperature testing and fire safety tests. We saw that there were certificates in place to evidence that checks

were being undertaken on a range of equipment such as, moving and handling slings, electrical testing and water temperature checks.

The service was found to be clean and well maintained. People's room were individual and people have some of their own personal items making the rooms homely. There were systems in place to protect people from the risk of acquired infection. Staff were observed to comply with hand washing protocols and also used the anti-bacterial hand gel from dispensers which were visible all around the service. Staff had received training in infection control as evidenced from discussions with staff and a review of staff training information held by the service. The service was found to be clean and fresh smelling. Furnishing and carpets were in a satisfactory condition. Regular cleaning and checks on mattresses were carried out and records maintained of these checks.

Good

Is the service effective?

Our findings

People received their care from staff who had been appropriately supported with training. Staff records and discussions with staff evidenced that newly appointed staff were provided with induction training and opportunities to shadow other staff. Staff told us that since the appointment of a training coordinator the quality of the training was steadily improving. However, it was also evident from discussions with staff that further work was needed to ensure staff were provided with training relevant to the work they were employed to perform.

Staff had received a variety of training in health and safety awareness and opportunities to work towards recognised qualifications such as the Quality Care Framework (QCF). Discussions with the staff and the training coordinator highlighted a need for further training to support staff in understanding and meeting the needs of people diagnosed with Parkinson's disease and also the care and support needs of people living with dementia. The training coordinator told us they were currently looking into accessing training for staff in health related conditions such as Parkinson's disease and were also putting together a training programme to support staff with updating their skills and knowledge in dementia care awareness. The manager also told us that they and the activities coordinator were attending external training to support them to increase their skills and knowledge which would then be cascaded to the staff team.

Staff told us that support with one to one supervision to discuss their training and development needs had been sporadic but they did have opportunities for regular staff meetings, where they were able to express any concerns they might have and where team work performance issues were discussed. One member of staff told us, "Everything is talked about and they put a list on the wall and you can add anything you want to talk about at the meeting. Carers, kitchen, nurses and cleaners all have their own meetings and then a general one with all every couple of months – you don't feel that you cannot say something"

Staff handover meetings took place daily where updates and regarding people's changing needs were discussed. However, not all staff were invited to attend these meetings as specific staff were appointed daily to feedback to others what was discussed. Staff told us that if they were not present they did not always receive information from the meeting if staff were busy. This they told us on occasions had meant important information had not always been cascaded to those who would need to know. This had the potential to put people at risk of not having their changing care and treatment needs met if staff were not provided with timely, up to date information.

Staff had received training in understanding their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and related Deprivation of Liberty Safeguards. This meant that staff had obtained the required knowledge to identify when a person without capacity needed specialist support to ensure that their best interests were assessed and guidance provided for staff. For example, we saw that the registered manager accessed advice from the local safeguarding authority when assessment of a person's mental capacity had highlighted questions with regards to a possible deprivation of their liberty.

People were supported with their healthcare needs. Care plans included details of people's health

conditions and planning to support people to maintain their health and wellbeing. We saw that people's health and wellbeing was regularly monitored. For example, the monitoring of blood sugars for people with a diagnoses of diabetes and blood pressure checks. All of the relative's we spoke with told us staff supported their relative to access health care when required and kept them informed of any changes.

People were supported to eat and drink according to their dietary needs, choices, wishes and preferences. Everyone we spoke with was complimentary about the quality of the food provided. One person said, "The food is lovely. There are two or three things to choose from each day. It is hot and plenty of it. They always ask have you had enough if there is something you don't like they will do an omelette or jacket potato for you." Another told us, "The food is alright. I have mash and can manage myself but someone is always here to help me. They ask are you hungry and if you say yes get you a cup of tea and biscuits or cake." One relative told us, [Relative] does not like the homemade soup so they go out and buy the named brand which they do like. We are quite impressed with what we have seen." Another relative said, "The food is quite good, it is home cooked food." Where people required support with eating their meal, this was provided in a caring, respectful manner.

Kitchen staff described to us how they considered the needs of people who required a fortified diet to support them with access to food fortified with additional calories where they had been assessed as at risk of inadequate nutritional intake. They also described how they would support people who had specialist dietary needs. For example, providing a reduced sugar intake where people had a diagnoses of diabetes, gluten free, vegetarian and cultural specific requirements.

The main menu was varied and creative. The cook told us that 90% of the food provided was with fresh ingredients and cooked from scratch. They also told us, "If someone requires alternatives from the menu we can do that, it's a case whatever the resident requires we will always oblige." We observed the midday meal to be well presented, appealing and nutritious.

Good

Is the service caring?

Our findings

Staff were knowledgeable about the people they cared for and spoke with empathy and kindness about their work and the people they supported.

People told us that all the staff and the registered manager showed them kindness and compassion. One person told us, "Care is very good, staff are brilliant and do anything and everything you ask." Another told us, "Yes they are caring, fairly respectful but the young and old don't always mix. I can't understand some staff when they speak but they are all kind."

Staff were observed not to rush people and spent time chatting to people when they were able to. Staff were observed to knock on people's doors and wait before entering to be invited in. One member of care staff was observed to enter a person's room once invited in, chatted to the person asking if they had enjoyed their birthday and admired the flowers they had received. Where staff supported people with limited mobility, staff were observed to explain what they were doing. When supported to mobilise in bed staff were observed to ask, "Which way do you want to roll, ok roll towards [staff member] and I will put the two pillows here, I will go gently." This task was carried out in an unrushed manner and with kindness and care

People told us staff treated them with respect when supporting them with their personal care. One person told us, "Yes they are sensitive to my need for dignity. I never thought it would come to my needing help with having a wash but you make the best of what you can't; change and they are all very kind." One relative told us, "My [relative] has dementia and it is not an easy job but the young people here have a caring attitude. They are very good with them." Another relative told us, "I come daily and I know all the staff very well and it is very good here."

People told us their views were respected with regards to the times they chose to get up and go to bed, what they wore and how they like to spend their time. Wherever possible people were involved in making decisions about their care and their relatives were appropriately involved. One relative told us, "There are no restrictions on visiting. I have never been told of a time when I could not come to visit."

We spent time with people in the communal areas and observed there was a relaxed and caring atmosphere. People were comfortable and relaxed around staff. We saw that staff encouraged people to express their views and listened with interest and patience to their responses. Staff were not rushed in their approach and gave time to listen to people. When supporting people with eating their meal, staff supported people whilst sat at eye level and spoke to them throughout the meal in an un-rushed manner.

Requires Improvement

Is the service responsive?

Our findings

The provider had employed the services of a nurse consultant to implement new care planning documentation. Care plans contained more comprehensive information than we had seen at our previous inspections and it was evident a great deal of work had gone into implementing the new format.

People's needs had been assessed prior to their moving into the service. People's health care needs were recorded and input from other healthcare professional described. However, further work was needed to ensure that care plans were reviewed and updated in a timely manner to reflect people's changing needs. Care plan summaries used to provide a brief pen picture of a person's daily needs and a useful tool to guide new and agency staff, the information was not consistent with what was recorded in the person's overall plan of care. For example, in relation to whether or not people had mental capacity or had a 'do not attempt cardio-pulmonary resuscitation', (DNAR) in place. This had the potential to put people at risk of not having their needs, wishes and preferences met in considering their capacity to consent to treatment and whether or not to resuscitate in the event of a health emergency. Where weekly weighs had been advised following specialist advice in relation to people who had been losing weight and assessed as at risk of inadequate nutrition, this information had not always been updated into the care plan and communicated to staff effectively to ensure this action was carried out.

The service was recognised as a place where people could be referred to, to access end of life care. However, information within care plans in relation to the assessment of people's needs, wishes and preferences in planning for their end of life care was found to be minimal. In some cases information provided did not adequately inform staff as to any discussions with people in assessment of their personalised needs and guidance as to how they would want to receive their care and treatment at the end of life. Where it was not possible to obtain this information this also had not been documented. This had the potential to put people at risk of not having their care and treatment needs met.

In relation to assessment and planning for people's 'spiritual cultural and religious needs', information in care plans was again minimal. For example, one person where it was recorded, ' [person] is an Atheist and therefore has no further religious or spiritual needs', there was information in this section around this person liking, 'a cooked breakfast, Sunday roast and fish and Chips'. This led us to believe that assessment of people's needs in this area had not been understood by the person carrying out the assessment.

The local authority, quality and improvement team had recently been involved in supporting the service to improve the quality of their care plans. They had advised the provider of improvements in a number of areas. They provided guidance to enable the provider to develop more personalised care plans in relation to assessment of people's needs and incorporating a person's choices, wishes and preferences about how they lived their daily lives and received their care and treatment. The manager told us this was still a work in progress.

The service employed and activities organiser who supported people with group and one to one activities which included supporting people to access the local community. We observed on the day of our inspection

people supported with one to one activities such as manicures or having their hair done. Some people were supported to pursue some leisure activities and hobbies according their personal wishes and preferences. For example, we observed people were supported to participate in placing bets at the local bookmakers, this activity they told us they enjoyed all their lives and valued the opportunity to continue with this.

People told us they enjoyed the activities provided. However, they also told us that the weekly activity planner placed on notice boards throughout the service for people to view did not always accurately reflect the activities provided. Any changes or cancellations, they told us were not always communicated to them as they would have liked. People told us that staff respected their wishes when they wanted to be alone and encouraged those who enjoyed the company of others to participate in group activities.

People said that they were supported to voice any concerns they might have and the manager had been supportive in listening to suggestions they had made to improve the service. One person said, "I did complain once and the manager dealt with my concerns to my satisfaction." Another told us, "There are no residents meetings, not to my knowledge but the Manager is always available and I can talk to any of the staff." One relative told us, "I complained twice – the sheets were worn last year and they got new ones. Another time I found a large gap in the care book of four hours and I was told that someone had not signed the book. It was last year but they sorted out my concerns quickly. I do feel I am listened to and taken seriously." People also told us they were not aware of any formal complaints policy or procedures. We noted that there was little information available on notice boards with information which would guide people to the provider's complaint procedures or formats for making suggestions to improvements to the service such as suggestion boxes and outcome of any satisfaction surveys.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager who was also the registered provider. The registered manager was not a qualified nurse. As the registered service is a care home with nursing, we found that there was no clinical lead appointed for the service with effective oversight of clinical governance.
The provider employed a consultant who in part fulfilled this role and responsible for implementing new care planning documentation. However, nursing staff told us that there was no clinical lead in place with overall clinical leadership responsibility for monitoring nursing standards. This they told us had led to confusion as to who was responsible for monitoring the standard of nursing and supporting them with oversight of their clinical professional development.

There was no designated person appointed as responsible to carry out the role of 'confirmer'. This is a person with the delegated responsibility to assess whether or not employed nurses have demonstrated their understanding and have carried out as required their revalidation. An appointed 'confirmer' would be responsible for ensuring that nursing staff have met the requirements for revalidation. For example, assessing and evidencing that nurses have complied with the steps they should take to comply with the three yearly revalidation of nurses in accordance with the National Midwifery and Nursing Council, (NMC) requirements. Discussions with the manager, training coordinator and the nurse consultant along with a review of nursing staff personnel files showed us that nursing staff had not been regularly supported with regular clinical supervision and supported with planning for their clinical professional development. We were therefore not assured that action had been taken where registration with a professional body was a requirement of the role staff had been supported with clinical supervision to support revalidation and meeting codes of practice. This also had the potential to put people's health, welfare and safety at risk.

This demonstrated a breach of Regulation 18 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall management arrangements for auditing people's medicines were in need of improvement. The provider's audits were found to be sporadic, irregular and did not identify the shortfalls we found in relation to qualified nurses management of people's medicines and inadequate medicines management policy. There was no clear, established system of clinical governance in place and operated effectively with regularity which would ensure regular assessment and monitoring of risk in relation to the regulated activity which included nursing care. This meant there was a lack of business planning which would clearly summarise the organisations aims and objectives for both the care service with well-defined plans for continuous improvement.

This demonstrated a breach of Regulation 17 (1)(2)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were in the main complimentary in their views regarding the management of the service. One relative told us, "The manager is very good, very helpful and was very helpful with the move of our [relative] from the previous home they lived in. They organised the ambulance to bring them here – we are very

satisfied" Another relative told us, "The atmosphere is good, it is well maintained, bright and not too much institutionalised. Staff are relaxed and easy going and [relative] has no problems with any of them. The manager is easy to talk to and comes round and talks to [relative]."

Staff were generally complimentary about the management and leadership of the service. One member of staff told us, "I love it here, I love assisting people and helping them to be presentable clean and happy. This is their home, their needs come first. We are a good team and everyone gets on." Another told us, "The manager is good and knows what she is doing and she listens and deals with things."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines had not always been administered accurately, in accordance with prescriber's instructions to make sure that people who used the service were not put at risk. The provider's medicines policy failed to provide guidance to the level of detail required in line with current legislation and National Institute for Clinical Excellence (NICE) guidance for managing medicines in care homes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality and safety monitoring of the service was sporadic and ineffective in identifying where quality and safety of the service was being compromised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was a lack of a lead person responsible for overall clinical governance and appropriate systems in place to support nursing staff with clinical supervision and evidence in meeting codes of practice in relation to the revalidation of nurses.