Castlemeadow Care Home (Halesworth) Ltd

Highfield House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Highfield House Care Home is a residential care home providing accommodation for up to 40 people. The service is arranged over two floors and a third storey referred to as a mezzanine. At the time of this inspection there were 28 people using the service.

People's experience of using this service and what we found

There were insufficient staff to meet people's needs. This meant people had to wait for personal care and support, staff were not available to respond to people in a timely manner. The service had experienced a high turnover of staff and challenges recruiting. As a result, the staff team was running on a high level of agency staff. The home had a core group of experienced care staff who had worked hard across the pandemic to provide a degree of consistency to people.

Medicines were not managed safely across the home. Risks to people's health, safety and welfare were not managed effectively, placing them at significant risk of harm. People's care records were not always person centred and accurate. They lacked accurate and up to date information to guide staff in how to meet their needs safely and effectively.

People were mostly protected from the risks associated with the spread of infection, including from COVID-19. We signposted the provider to further work needed.

The provider's governance systems to monitor the quality and safety of the service were inadequate. The provider's lack of oversight meant some previously evidenced standards and regulatory compliance had not been maintained. The lack of robust governance systems meant the provider had failed to identify and address issues we found.

Most people and relatives commented positively on the care they received from the regular and consistent staff team who they recognised worked hard under pressure due to staffing levels.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 10 May 2021) and there was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations. This service has been rated requires improvement for the last two consecutive inspections. This inspection has been rated inadequate.

Why we inspected

We received concerns in relation to staffing levels, infection control practice and the management of the home. As a result, we undertook an unannounced focused inspection to review the key questions of safe and well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Highfield House Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicines, assessing risk, infection control, health and safety staffing, recruitment and governance.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Highfield House Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors, a medicines inspector who specifically looked at the safe management of people's medicines, and a specialist advisor who was a nurse. Following our visit on site an Expert by Experience made telephone calls to people and their relatives to seek their feedback. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Service and service type
Highfield House Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return (PIR) prior to this inspection. The PIR is information we require providers to send us to give some key information about the service, what the service does well and

improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 14 people who used the service about their experience of the care provided. We also had feedback from seven people's relatives. We had contact with 13 members of staff, the acting deputy manager, acting manager and the provider's regional manager.

We observed people's care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included people's care records and medication records. We looked at a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- We were not assured that risks to the health, safety and well-being of people were suitably assessed or appropriately monitored within the home. This was because the care records we looked at either were out of date or contained conflicting information.
- Where risks were identified, action was not always taken to reduce the risk of harm to people. For example, we were concerned about several people's nutritional care and weight loss. Records did not evidence that people were being supported to gain and maintain weight where this was necessary.
- People were not always protected from risks of poor nutrition due to insufficient record keeping. For example, a number of people had lost weight over the previous 12 months. However, despite healthcare professional advice in May 2021 identifying gaps in records and making recommendations with regards to nutritional plans, there were no records to evidence this was occurring. Where people had a daily food intake record, these were not always filled out correctly and action taken where people had refused to eat sufficient amounts recorded.
- People's hydration needs were not being properly monitored and recorded to ensure unnecessary dehydration and weight loss. For people at risk, their fluid intake was not consistently recorded or totalled in order that their intake be monitored.
- Records relating to people's safety were not always up to date or accurate. This meant that staff were unable to follow guidance to help ensure people were consistently supported safely. This was of particular risk and concern because the home was using a lot of bank and agency staff.
- Environmental risks were not always picked up and appropriate action taken to ensure people's safety. During our inspection visit we found fire doors and cupboards that were clearly signed 'keep closed' were left open. This was of further concern as one area was for the storage of hand sanitiser gel that could have been potentially harmful if someone had ingested it. No risk assessment had been undertaken relating to ingestion risk this posed to people.

Using medicines safely

- Medicines requiring refrigeration were kept in a medicine refrigerator, however, we noted gaps in the temperature records therefore the records could not provide assurances that the medicines were stored at correct temperatures at all times.
- For some people, there was no form of personal identification available to assist in ensuring staff correctly gave people their medicines and some records about people's medicine allergies were recorded inconsistently which could have led to medicine errors.
- Written guidance for medicines prescribed on a when required basis (PRN) was not available for some medicines prescribed in this way to ensure they were given by staff consistently and appropriately. However,

additionally, some PRN guidance was available for medicines that were no longer prescribed which could have led to confusion and error.

● Some medicines had not recently been available to give to people for several days because they had not been obtained in time. In addition, we identified that when one person did not receive one of their medicines it had been in back up storage in the medicine room during this time.

● There were several large containers of excess medicines on the floor of the medicine room awaiting disposal to the pharmacy that had been there for a prolonged period of time and not yet removed.

● There were gaps in records of medicine administration and discrepancies in records against quantities of medicines available at the service. This suggested some people may have not received their medicines or had received incorrect doses of them. We found that records for the application of topical medicines were mostly not completed.

● We also noted that controlled drugs for two people were recorded in the controlled drug register but that were no longer present in the cabinet used for the storage of controlled drugs. We asked the manager to investigate this following which they provided us with an update and report on their findings.

● For people who were prescribed medicated skin patches, records did not always show that when new patches were applied, their previous patch was removed for safety. In addition, there was no system in place to ensure that the sites of application on people's bodies were rotated appropriately to reduce the risks of skin effects.

● A person living at the service told us that staff sometimes woke them up in the evenings to give them their medicines. Staff had not taken action to arrange a review of times for the administration of their medicines.

● We noted that when contact was made with prescriber's about people's medicines, records about this were not always completed.

● People were encouraged to remain independent and manage some of their medicines, however, we found that the service had not always assessed the risks around this.

The shortfalls we found in the management of risk and medicines demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

● People living at the service told us there had been insufficient staffing levels for several months resulting in delays in them receiving their care. One person told us, "They are very short of staff there is not enough. I have to wait a long time for them to come to me. They never say why they have been so long." Another person said, "The staff are always so busy, the worst thing here is that I have to wait at least half an hour for the toilet when I need to go. It happens often."

● At our last inspection in September 2020, the provider had told us that they were in the process of addressing staff shortages. However, we found that progress had been insufficient.

● The service was heavily reliant on agency staff to meet staffing gaps. In excess of 200 hours a week of agency staff hours were being used during September 2021 and October 2021 alone.

● We were told by people, their relatives and staff that a number of the agency staff did not speak English as a first language and did not always have sufficient grasp of the English language to enable them to perform the job role effectively. People and their relatives told us this impacted communication. Staff spoke of challenges sharing information and safe working due to language barriers. One person said, "I am happy with the regular staff but not all the agency staff as they do not speak enough English and have not got their heart in it and I feel uncomfortable about it. I am not happy having two men from the agency staff put me to bed as they have to do everything for me. I can't choose to have female staff." Another person commented, "There is quite a lot of agency staff they are alright if you can understand them. Some days I get in a muddle with it." A third person commented, "I wish they didn't have to rely on agency staff."

● Some relatives also told us of their concerns at the staff shortages and the impact on their family member

of the frequency of agency staff working at the service. One relative commented, "[Family member] gets frustrated as she has to keep telling the staff things as there are lots of different staff."

We found no evidence that people had been harmed however, despite the provider giving us assurances they would improve staffing levels, this was a repeated breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● People were supported by staff who had been recruited safely. Pre-employment checks included obtaining references and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and help prevent unsuitable people from working in care services.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. There were inconstancies with ventilation in the home and some doors, that should have been securely closed, were left open. There were also some shortfalls with cleaning practice that had not been picked up in the local audits completed.

These concerns were shared with the provider in order that they could develop their approach.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse
● Staff explained how they would raise their concerns and the importance of protecting people from harm.
● There was information visible to staff in the service explaining how they could raise a whistleblowing concern should they have felt it necessary.
● Staff received training in safeguarding to provide them with the skills and learning needed for their job role.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The provider had failed to ensure the service was well-led and as a result people were at risk of not receiving proper and safe care. This is the third inspection where the service has not reached a Good rating overall.
- The provider's quality assurance systems were not robust. There was ineffective governance and poor oversight at manager, regional manager and provider level which had failed to fully identify shortfalls in the service putting people at risk of harm.
- Governance and monitoring systems were not robust and failed to identify shortfalls and ensure appropriate action was taken. This lack of oversight had led to the quality of care deteriorating.
- Staff were not clear on their job role and responsibilities. The high use of agency staff, and unclear lines of accountability and leadership had led to poor communication and outcomes for people. This was apparent in the management in the delivery of care and in care plans such as nutritional and hydration risk where records did not demonstrate that people were receiving the care and support, they required.
- Over the past three years there had been a number of management changes which had destabilised the service and resulted in inconsistency in approach. At our last inspection the senior management team displayed a commitment to making the necessary improvements and changes however this had not taken place.
- Environmental audits did not identify and mitigate safety concerns relating to the cupboard and fire doors left open which made parts of the service unsafe for people.
- The service has been without a registered manager since July 2021. It is a requirement of the providers registration that they have a manager who has registered with CQC in post.
- The service did not always work in partnership with others. Advice from professionals was not always followed. For example, when people had been losing weight and action was needed to monitor and prevent any further concerns.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had failed to ensure people were receiving care that met their individual needs. Care plans were not consistent, accurate or kept up to date to give staff the instructions they needed to provide person centred care.
- We were not always assured that a positive, person-centred, inclusive approach to care was being

achieved.
● Areas of risk were not being effectively monitored and health and well-being of people living at the home was not routinely assessed.
● Some staff told us they felt unsupported and under-valued by the provider and felt their concerns were not listened to.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Several relatives told us the provider had not always acted openly when something had gone wrong. One relative said, "[Family member] had an accident. They [the care home] did not tell me until twenty-four hours later." Another relative commented, "Only thing is [family member] has had a couple of falls and we were not notified until the next day."

The above shortfalls constituted a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service displayed their previous rating as they are required to do.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The deployment of staff was not sufficient to ensure that people's needs were met in a timely manner.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's care and treatment were not always planned and managed in a way that promoted the health, safety and wellbeing of people.

The enforcement action we took:

We issued the provider with a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have robust and effective systems in place to monitor, assess and improve the safety and quality of service being provided. The serious and varied nature of the breaches of the five regulations we have identified demonstrate a failure of leadership and governance at the service.

The enforcement action we took:

We issued the provider with a warning notice