Mr & Mrs D H Willcox

Highcroft Nursing Home

Inspection report

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27 November 2020
10 December 2020

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Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

About the service
Highcroft Nursing Home is a nursing home providing personal and nursing care for up to 23 people. At the time of the inspection 20 people were living at the home.

People's experience of using this service and what we found
Risks relating to infection control were not all being managed safely. Staff were not all wearing their personal protective equipment (PPE) correctly. Some additional information was required for medicines administered on a 'when required' basis.

There were enough staff available to meet people's needs. Staff were recruited safely. Medicines were stored securely and safely. Risks to people were identified and guidance was in place for staff to reduce the level of risk. Checks were in place to ensure the environment and equipment was safe.

People's relatives and staff commented positively about the leadership and management of the service. Staff told us although they had experienced a difficult time, morale and teamwork remained good.

Governance systems were in place to monitor the quality of service and the health, safety and welfare of people. There were systems in place to communicate with people and relatives. People's relatives were very complimentary about the care their family member received.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was Good (published August 2019).

Why we inspected
We received information of concern about infection control and prevention measures at this service. The provider had an outbreak of Coronavirus. This was a targeted inspection looking at the infection control and prevention measures the provider has in place.

We inspected and found there was a concern with infection control procedures, so we widened the scope of the inspection to become a focused inspection which included the key questions of Safe and Well-Led.

We have identified a breach in relation to safe care and treatment at this inspection.

Information about CQC's response to the breach in regulations can be found at the end of this report.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Good

The service was not always well-led.

Details are in our well-Led findings below.

Highcroft Nursing Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by and inspector and a specialist advisor who was a nurse.

Highcroft Nursing 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was carried out on 25 and 27 November 2020 and 10 December 2020. The first two days of the inspection were unannounced, the third was announced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We reviewed a range of records. This included people's medicine records. We also reviewed records relating to the management of the service such as incident and accident records, recruitment records, health and safety records, training records and audits. We carried out observations of infection control practice. We

spoke with the administrator at the service and the registered manager on the telephone.

After the inspection
We spoke with five relatives, the registered manager, the service manager and four staff members via the telephone. We reviewed people's care records and continued to seek clarification from the service to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- Risks relating to infection control were not all being managed safely. We observed staff were not always wearing personal protective equipment (PPE) appropriately.
- We observed the disposal of PPE was not being completed in line with good practice.
- Arrangements to wash the laundry were not being carried out appropriately, to prevent cross infection.
- Staff had scrubs provided by the provider, however they were not changing into these at the point of entry into the home. This increased the risk of the spread of infection.
- One person's risk assessment who was recently admitted to the home stated they should be isolated in their room for 10 days, rather than the 14 days detailed in the government's guidance.

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

- We discussed this with the administration staff who took action in response to our concerns. This included ensuring the laundry was being laundered in line with current guidance, raising awareness regarding PPE, arranging additional training for staff and changing the arrangements for staff changing into their uniforms.
- There were dedicated cleaning staff in the home who had increased their cleaning schedule to ensure more frequent cleaning particularly areas such as door handles and light switches.
- The home was clean and free from malodours. Relatives confirmed the home was clean.
- Prior to the current outbreak the home had been free of COVID-19.
- People had risk assessments in place regarding the risk relating to COVID 19.
- There was a visiting policy in place, although the home was currently closed to visitors.
- Staff received infection control training and had access to enough suitable PPE.

Using medicines safely

- Some people were prescribed medicines on a 'when required' basis (PRN) for example pain relief. Whilst there was some guidance on the medicines administration records (MARs) on how to give these medicines, there were not individualised plans in place. Individualised plans give staff guidance on the signs to look out for the person that requires the medicines, what the medicines are for and contraindications with other medicines. We discussed this with the registered manager who told us the nurses administered medicines, which reduced the risk of inappropriate administration. The registered manager confirmed they would review this.
- The MARs we reviewed contained some hand-written recorded entries, two of these entries were not

double signed by staff. Double signing hand written entries on MARs prevents the likelihood of a transcribing error.
● There were systems in place to record the application of creams and other external preparations. Records were completed by the nurses and not the care staff administering them.
● Medicines were discussed and reviewed with the GP when they attended their two weekly round at the home.
● Medicines were stored securely. Suitable arrangements were in place for medicines needing extra security.
● There were suitable systems in place for the ordering, administering, monitoring and disposal of medicines.

Assessing risk, safety monitoring and management
● Risks to people were identified and there were plans in place to mitigate the risks. Areas covered included falls, deterioration in health and pressure care.
● Staff told us they had access to the risk assessments and any changes were communicated through handovers and the electronic care planning system.
● The homes environment and equipment were maintained. Records were kept of regular health and safety and environmental checks. Fire alarms and other emergency aids were regularly tested and serviced.
● There were emergency plans in place to ensure people were supported to evacuate in an emergency.

Systems and processes to safeguard people from the risk of abuse
● Relatives told us people were safe at Highcroft Nursing Home. One relative told us, "Yes I'm happy [name of person] is safe, I wouldn't put them anywhere else, it's the best care I would wish for." Another relative commented, "Yes I do think [name of person] is safe. They look after them incredibly well and take care for them as individuals, they are very caring."
● There had been no recent safeguarding concerns at the service. The registered manager was aware of their responsibility to report any concerns to the local authority and the Care Quality Commission (CQC).
● There were safeguarding systems in place. Staff understood how to recognise abuse and report it internally and externally. One staff member told us, "I would report anything I was concerned about to the senior and the [registered] manager, if nothing was done I would inform CQC. I am aware of the whistleblowing procedure."

Staffing and recruitment
● Relatives told us they had no concerns about staffing. One relative told us, "Staffing levels always appear to be satisfactory. They never look like they are trying to catch their tails and they have time to do their jobs. I can't remember the last time I saw a new face."
● There had been staff absence in the service due to COVID 19. Staff told us it had been, "A bit short at times", however they told us they were managing by staff picking up additional shifts and the use of agency staff. Comments from staff included, "We are a bit short recently, normally we are fully staffed. Everyone helps out, we work together as a team, we pick up extra hours. It's been ok, not unsafe, we meet their [people's] needs and the most important things are done."
● Although there had been some staff absence relating to COVID 19, the home remained safely staffed. The administration staff had arranged for sickness to be covered by permanent staff picking up additional shifts and agency use where required. The same agency staff were requested to cover the shifts and shifts were block booked to prevent additional staff entering the home during the outbreak.
● We reviewed the staffing rotas and shifts were covered.
● Safe recruitment systems were in place to ensure only suitable staff were employed. We identified gaps in employment for one staff member employed. Having unexplored gaps in employment could impact on a staff member's suitability to work with vulnerable adults. The administrator told us they would address this.

Learning lessons when things go wrong

● There were systems in place to ensure accidents and incidents were recorded and investigated. Incident records considered factors that could have contributed to the incident. For example, staffing levels, time of day and the environment.

● Incidents and accidents were reviewed monthly and six monthly by the service manager.

Good

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 Good. At this inspection this key question has remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Due to the COVID 19 outbreak in the home, at the time of the inspection the registered manager, two nurses, and a senior member of staff were absent from the service. The service manager was staying at the home and self-isolating. The administrator was overseeing the home with the remote support of the registered manager and service manager.
- The providers medicines policy did not fully cover the requirements for the use of 'when required' medicines.
- There was a COVID 19 contingency plan in place, which the registered manager told us had worked well.
- There were systems in place to monitor the standard of care provided at the service. The registered manager and provider had a range of audits and action plans in place to identify shortfalls and areas of improvement.
- Statutory notifications had been submitted by the registered manager in line with their legal responsibilities.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People's relatives told us they thought the service was well led and there was a positive staff culture. They felt able to approach the registered manager and service manager with any concerns. Although they all commented they did not have any concerns about their relative's care. One relative told us, "The service is run exceptionally well, they are like a family, I can't fault them." Another relative commented, "I'm very impressed with how the home is run, they are very flexible and work as a team."
- Staff told us the registered manager and service manager were both available and approachable. One staff member told us, "[Name of registered manager] is approachable and [name of service manager] is committed to the home." Another commented, "The [registered] manager is very good and I feel supported."
- Staff told us although it had been tough regarding the outbreak in the home, the staff all worked well together to support each other and the home. One staff member told us, "It's been a bit stressful, we have worked hard trying to get through this period, we work all together as a team all of us. Everybody helps each other." Another commented, "It's a difficult time, I think we are all making an effort and morale is quite high, we are all in it together."
- Staff told us they were committed to providing good care and positive outcomes for people. One staff member told us, "We want the residents to be happy and for it to feel like their home, we talk to them, they

tell us about their worries. We want to make them comfortable, happy, laugh and take good care of them."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager and service manager understood their responsibility to let others know if something went wrong in response to their duty of candour.

● There were systems in place to ensure the duty of candour was followed. When incidents occurred in the home the registered manager considered the duty of candour and recorded on the incident form where relevant parties, such as people's relatives, were informed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives told us communication with the home was good. One relative told us, "Communication has been very good, I have regular contact from them weekly, and I phone in every couple of days." Another relative commented, "They have communicated exceptionally, I can't fault them."

● Information relating to COVID 19 had been communicated to people and their relatives.

● Staff confirmed they attended staff meetings, although these were not regular. They confirmed key messages were discussed during handovers and these were recorded. One staff member said, "We have them [staff meetings] but not often, we talk about relevant subjects, we also have daily handovers, and information is shared on the tablet [electronic care planning system]. We can see what's happening, all information is computerised and we can access it when we like."

● Staff told us communication in the home was good, they felt listened to and had access to up to date information and guidance.

● An annual survey was carried out to seek feedback from people and their relatives. Feedback from the survey was incorporated into an annual plan that identified any areas for improvement.

Continuous learning and improving care; Working in partnership with others

● The service worked in partnership with other organisations to support care provision. For example, a range of health professionals.

● The service maintained a record of accidents and incidents showing the details, action taken and outcomes. This supported any future learning from such events.

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 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Infection control procedures did not protect people from risk of the spread of infection. Regulation 12 (2) (h)