Dhillon Care Services Ltd

Highview Home

Inspection report

12 Priory Road
Dudley
West Midlands
DY1 4AD

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03 November 2021
04 November 2021

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13 July 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Highview Home is a residential care home registered to provide accommodation and personal care for up to 24 people. Support is provided to older people and people living with dementia. At the time of inspection there were 22 people.

People's experience of using this service and what we found
Governance systems were not always effective to ensure care plans contained enough guidance for staff to follow. Governance systems had not identified that care plans were completed in line with peoples needs and wishes. Medicine management audits had not identified that stock was not being controlled in order to ensure continuity of medication.

There was no Registered Manager at the service at the time of Inspection. A manager had recently been appointed who was applying for registration with the Care Quality Commission.
People, relatives and staff we spoke to, knew who the newly appointed manager was, and felt able to approach them. Staff felt the newly appointed manager had started to make improvements to the service, whilst we did see some improvement, further improvement was required.

People did not always receive person centred care and there were not enough activities available for people to enjoy. People and relatives were not consulted about their wishes about the end of their life and were not involved in reviews of their care.

People told us they felt safe and staff knew how to recognise and report safeguarding concerns. At our last inspection we found concerns in relation to infection control practices. At this
inspection we found the provider had taken action in response to our concerns and had made improvements.

People told us staff were kind and caring and treated them with dignity and respect and we observed some of this. However, there was a lack of systems in place to ensure the service was consistently caring and people were fully involved in their care.

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 requires improvement (published 06 May 2021) and there were multiple breaches 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 we found improvements had not been made and the provider was still in breach of regulations

At this inspection because we only looked at the 'Safe, Responsive and Well led' key questions. This was

because our planning did not identify any concerns about the other questions.

This service was registered with us on 17 April 2020.

Why we inspected
The inspection was prompted in part due to concerns received about the infection and control practices within the service and the care provided to people with distressed behaviours. A decision was made for us to inspect and examine those risks.

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.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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 regulation 9 safe management and processes and medicines management and person centred care. Regulation 12, safe care and treatment and regulation 17, governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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.

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 responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Highview 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
The inspection was carried out by two inspectors.

Service and service type
Highview 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.

At the time of the inspection visit the manager had applied to register with the Care Quality Commission but the process was not complete. This meant that only the provider is legally
responsible for how the service is run and for the quality and safety of the care provided.

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 who work with the service. 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 the last inspection of Highview Home Inspection into account when we inspected the service and made the judgements in this report

During the inspection
We spoke with three people who used the service and three relatives about their experience of the care provided. We spoke with five members of staff including the provider, manager, deputy manager, senior care worker and one care worker. We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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.

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

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 requires improvement. At this inspection this key question has remained as 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.

Assessing risk, safety monitoring and management; Using medicines safely

● Risk to people had not been appropriately managed. Where risks in relation to specific health care needs for people had been identified these were not been managed. One person required their fluid intake to be monitored. We found that staff were not monitoring the persons fluid intake. The risk assessment in place stated the amount of fluid the person should be drinking per day, but the risk assessment failed to guide staff to actions to take should these levels were not reached. Another person had been assessed as high risk of falls. We witnessed the person left alone in a communal area for over 20 minutes. The risk assessment did not identify any precautions staff could take to reduce the risk of falls.

● Guidelines were in place to support people who were at risk of choking when eating and drinking. However these did not always reflect the level of support the person needed. We also saw that there was inconsistency in following the guidelines regarding choking. We saw they were not followed through in practice, placing people at risk of harm. For example, two people at the home had identified risks of choking as assessed by Speech and Language Assessment (SALT). We saw that whilst one person had a choking risk assessment completed, the second person did not. Staff knew about the risks, but as no assessment was available staff were overstating the person's risk of choking and applying a higher assessment of risk than the person needed. This meant that the person potentially did not have access to certain foods due to the inaccurate assessment of risk. When we highlighted this to the manager, they changed the records to accurately reflect the persons dietary needs.

● Records we looked at showed when people had falls or accidents, their care plans and risk assessments had been reviewed and actions taken to mitigate risks, on most occasions. However, body maps were not available to show where injuries had been sustained in most cases.

● Staff we spoke with were not able to tell us about all the risks they needed to be aware of when supporting people. Staff told us they referred to care plans and risk assessments, but some of the assessments were not available. Examples of risk plans that were not available, would be diabetic risk assessments and choking risk assessments.

● We found that staff were not trained, nor did they have information about how to look for signs of changes in peoples blood sugars which may make them unwell. There was no training available at the time of inspection and staff could not tell us how they could identify if a person's blood sugar was low or high.

● We found that management of medicines was not conducted safely. One person had been prescribed two medications . One medication had not been given to the person for 11 days and the medication for the management of Diabetes medication had run out of stock on the morning of the inspection. It was concerning that the provider did not have a system to ensure that medication was available to people in

line with the prescription.
● When people required medicines to be administered on an 'as and when required' basis there was guidance in place for staff to follow so they would know when to give the medicine. However, when we checked Medicines Administration Records (MAR) charts, we found that staff had not taken action to ensure there were adequate stocks of medication and that there was no oversight of this lack of stock control.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.agree

Systems and processes to safeguard people from the risk of abuse
● People we spoke with told us they felt safe. A relative also told us, "We don't have any worries about [name] being safe, they [care staff] always contact us if they have any concerns or if anything changes".
● Where a safeguarding incident had been identified, the relevant agencies had been notified and action had been taken by the service.
● Although training records showed some staff were yet to complete their safeguarding training; the staff we spoke with were aware of their legal duty to keep people safe from risk of abuse. They knew how and who to report concerns to.
● Staff were aware of the whistleblowing policy and told us how they would raise concern, ensuring people were protected.

Learning lessons when things go wrong
●Accidents and incidents were dealt with appropriately as and when they occurred. However, there were no systems in place to learn from incidents or identify possible themes in order to reduce the chance of a similar incident occurring again.

Preventing and controlling infection
● We were somewhat assured that the provider's infection prevention and control policy was up to date. The provider's contingency plan and risk assessments for staff had not fully explored or mitigated all risks. For example, the contingency plan did not include how they would ensure safe staffing levels if staff became ill with COVID-19.
● We were somewhat assured the provider was facilitating visits for people living in the home in accordance with the current guidance. People had not been supported to have named visitors coming into the home. After raising our concerns with the manager, they assured us they would take action to address this.
● 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 promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment

● People told us care staff were available when they needed help.
● Staff we spoke with told us they had supervisions and felt supported.
● There were no issues identified with the provider recruitment processes.
● Our observations during the day, indicated there were usually enough staff on duty to meet people's identified needs. However, during meal times staff were not deployed so that they were available to support people. The provider told us that they would be extending the cooks hours to release the support staff from the kitchen in order to ensure an extra person was in dining room during meals.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained as requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; End of life care and support

●One relative told us, "[Person] is usually in their room, but I don't see much going on".

● Some people chose to stay in their rooms and there were no leisure opportunities or time spent with them apart from the care provided. We observed one person calling from their room and saying, "I am bored".

● During the inspection we observed people sat for long periods with little interaction and no objects of interest or activities available to them. We did see an activity with a balloon for a short period of time which people enjoyed.

● We saw little evidence that the activities carried out were tailored to people's individual needs. One person's care plan said they enjoyed gardening but there were no planned activities to reflect this.

●People told us they could not recall being involved in reviews of their care. Whilst we could see evidence of communication with relatives, when care plans had been reviewed there were no records of who was involved and what was discussed.

● There was no evidence people and relatives had been consulted about their wishes about the care they would receive at the end of their life. The service had not explored people's preferences, choices, cultural or spiritual needs in relation to their end of life care. The manager confirmed these discussions had not taken place.

The provider had not ensured that people were supported with personalised care that reflected their needs. This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014; personalised care.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Some people's communication needs were identified in their care plans. One person was supported to communicate using picture cards.

● We observed people being shown the food on the plates at mealtimes in order to make an a choice of what they wanted to eat.

Improving care quality in response to complaints or concerns

● The provider had a complaints process in place and people knew who to speak to if they had any

concerns. People we spoke with knew who the manager was and said they came to speak to them and would feel comfortable to raise concerns. There were no recent complaints recorded . However, the provider had no system for analysing trends of incidents and could not tell us how they would ensure that the risk accidents and incidents would be managed to reduce the risk of a reoccurrence.

Requires Improvement

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

- Governance systems had failed to ensure risk assessments and care plans provided sufficient guidance for staff to follow.
- There was no system in place to monitor accidents and incidents. There was no oversight or systems in place to analyse information and use lessons learnt to reduce the likelihood of re-occurrence. The manager told us they would put a system into place. However, this was identified at the last inspection and the provider had stated that action would be taken. At the time of this inspection this had not happened.
- Systems to ensure people's medicines were available to them were ineffective.
- Systems in place had failed to identify that the provider was not following their own policies. We found that three out of the four risk assessments we checked had not been updated since March 2021. The provider's policy stated these should be updated monthly or when there is any change in risk.
- The providers systems had failed to identify that they had not sought to find out people's views and wishes regarding their end of life wishes.
- The providers systems had failed to identify that all staff had received training in the management of Diabetes and End of Life care.
- Systems to ensure people were receiving person centred care and were engaged and involved in activities they enjoyed had been ineffective.
- There was no effective system in place to ensure that people were involved in reviews of care plans, which meant the service was not consistently promoting person centred care.
- Systems had failed to ensure that monitoring records were completed in line with people's needs.
- There was a culture of task-centred instead of person-centred care. We saw that staff were engaging with people, but usually about tasks they may require. There was no evidence of engaging people in activities or in conversations.
- The provider had completed an audit of staff records and identified some staff who required a new Disclosure and Barring Service (DBS) certificate due to the length of time since last issued.

The provider's failure to ensure that effective systems were in place was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

characteristics

● There is no effective system to ensure that peoples views on their service was regularly obtained. The last residents meeting was held in August 2021. The policy for 'residents meetings' is monthly. There is no evidence that any actions are taken from the meeting held in August when people expressed views.

● People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive was possible and in their best interests; the policies and systems in the home did not support this practice. Mental capacity assessments had not been completed for some key decisions when people lacked capacity.

● Regular staff meetings were held, and staff told us how the manager was making improvements to the service. One staff member told us "This manager listens and knows what they are doing, the provider is a very kind person and always helpful".

● People and relatives told us they knew who the manager was and they were approachable.

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; Continuous learning and improving care.

● The provider and manager were open and transparent during the inspection and demonstrated a willingness to listen and improve. The new manager had begun to make changes and improvements to the service, however further improvements were required. For example, they had started to update some of the Care Pans, however the plans and risk plans we saw did not address risks effectively.

● We saw improvements in infection control practices since the last inspection and the provider and manager had addressed the concerns we had identified.

● The training matrix seen had no training in end of life care, diabetic care or enhanced training in Hoist use. There were no incidents are accidents with regards to the use of Hoists. The manager has assured us that this will be a priority. We have seen evidence that Diabetic care training was made available since the date of inspection.

Working in partnership with others

● We saw that the provider worked in partnership with several different professionals to ensure that people's needs were met. For example, social workers, district nurses and pharmacists.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that people were supported with personalised care that reflected their needs. This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014; personalised care