GreenSquareAccord Limited

# High Mount

## Inspection report

13-14 High Mount
Donnington
Telford
Shropshire
TF2 7NL

Tel: 01952608082
Website: www.accordha.org.uk

Date of inspection visit:
04 April 2023
12 April 2023

Date of publication:
04 July 2023

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

High Mount is a residential care home that provides accommodation and personal care to a maximum of 8 people. The service provides support to people living with a learning disability. At the time of our inspection there were 8 people living at High Mount.

High Mount comprises of 2 single storey buildings that are situated in a cul-de-sac close to community amenities. Each building has 4 bedrooms, shared accessible bathrooms, communal living spaces and a shared garden.

We expect health and social care providers to guarantee people with a learning disability and autistic people, respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right Support, Right Care, Right Culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

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

Right Support: People were not always safe at High Mount. This was because the provider did not always ensure that risks were assessed, monitored, and managed to minimise the likelihood of harm.
People's hydration and nutritional needs were not always met which put people at increased risk of poor health outcomes. People's care plans were not always updated to reflect changes in need which meant care given did not always meet current needs.

Right Care: Health professionals' directions were not always followed which resulted in people not accessing health care services and not always receiving the care they needed to promote well-being. This meant people were exposed to continued risk of harm.
People were not always supported by enough staff, this meant care was not always person centred to maximise people's choice and control.
Environmental and equipment risks were not always identified and where they were, the provider failed to always act effectively to safeguard.

Right Culture: The provider failed to ensure the governance systems in place were always effective in delivering high quality care and support. Systems did not always identify or monitor effectively, to ensure risks were mitigated against, and, where increased concerns were identified through audit processes, no effective actions were taken to make the changes needed.

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 March 2019) 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 we found the provider remained in breach of regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service.
For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating has changed to Inadequate based on the findings of this inspection.

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 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 report.

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

Enforcement
We have identified breaches in relation to safe care and treatment and governance at this inspection. 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 request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore 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 6 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 of 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 always safe.

Details are in our safe findings below.

### Is the service well-led?

**Inadequate**

The service was not always well-led.

Details are in well-led findings below.

# High Mount

**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 Health and Social Care Act 2008.

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 2 inspectors.

Service and service type
High Mount is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. High Mount is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We reviewed information received by CQC about the service since the last inspection. We requested and reviewed information from the Local Authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We spoke with 5 people living at High Mount, observed care and support being given in the communal areas of the home and spoke with 2 relatives.
We spoke with 5 members of staff, which included the Registered Manager and Deputy Manager.

We reviewed a wide range of records, such as care plans, medication administration records, staff records, quality assurance documents and policies and procedures.
After the inspection we received further information from the provider regarding the governance of the service and continued to liaise with the Local Authority.

Inadequate

# Is the service safe?

## Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were not always safe and protected from identified risks of harm. Risks were not always effectively monitored and addressed which meant that appropriate actions were not always taken to promote health and well-being. For example, where 1 person had a Speech and Language Therapist (SALT) assessed diet due to a high risk of choking, staff did not always give them food in line with their SALT diet. This put the person at an increased risk of choking.
- Risk assessments were not always updated and where they were, different levels of need were being reported. For example, 1 person at high risk of falls had different levels of need recorded by staff. This placed the person at an increased risk of harm, as staff were not always aware of the actual level of care and support needed, to minimise the risk of falls.
- Care plans were recorded as being regularly reviewed, but changes in need were not always identified, which meant that care given did not always match people's current needs. We found 1 person, identified as at high risk of weight loss and hospital admission, did not receive increased weight monitoring when they needed it, which put them at increased risk of further weight loss and hospital admission.
- Effective action was not always taken to assess and manage environmental and equipment-related risks to minimise the likelihood of harm. We saw insecure hygiene waste in the grounds and in the home, equipment checks were not being regularly recorded as completed and hazardous to health substances such as cleaning products and ant killer were not stored securely. This placed people at increased risk of harm.
- Safety checks were not always completed by staff, which meant we could not be assured that equipment being used was safe, and in working order.

Learning lessons when things go wrong

- Systems in place were not used effectively to ensure incidents were reported, reviewed and learnt from to mitigate against future occurrence. For example, we were told that staff did not always report incidents using the provider's processes, which meant we could not be assured that all incidents in the home had been identified and investigated.
- Reviews and investigations were not always thorough as we found confusion with dates and actions taken following incidents, and we were not assured that lessons learnt were communicated effectively in the service.
- This meant people were not always safeguarded from the risk of avoidable harm.

Risks to people were not managed and the provider failed to take action to mitigate risk to people. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not always given as directed by the manufacturer's instructions. For example, 1 person's medicine instructions stated it was to be diluted in liquid. Staff did not do this and told us that was how they had been trained. The manager told us they would contact the GP and ensure directions for staff would be documented on the person's medicine administration record.

● Medicine administration audits did not always identify errors made by staff. This meant staff did not always receive additional training as needed to ensure they were competent.

● Medicine audits did not always identify stock levels accurately. This meant we could not be assured there were sufficient quantities of medicines available at all times, to prevent the risks associated with medicines, that are not administered as prescribed. This placed people at risk of harm.

The provider had failed to ensure that medicines were managed and administered safely. This placed people at harm. This was a breach of regulation 12(1) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse.

● People were not always safe and protected from abuse. For example, people's care, hydration and nutritional needs were not always met safely. We found people were not always supported to access health care services when needed and health professionals' directions were not always followed which placed people at risk of harm.

● People told us they liked living in High Mount and engaged with staff positively.

● Staff had received training in safeguarding and were able to tell us how they would recognise acts of abuse and who they would report it to.

Staffing and recruitment

● Staff were not always able to meet people's needs in a person-centred way to promote choice in line with Right Care, Right Support, Right Culture. Lower numbers of staff were working in the service, than we had been told were needed to meet people's needs when we inspected, this meant care became functional to meet basic needs.

● Relatives told us they were happy with the care and support provided at High Mount and told us "I'd give them 10/10, no complaints at all."

● People were recruited safely. Staff were required to have satisfactory references and DBS checks prior to starting their employment. DBS checks: Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● The service was not always working within the principles of the MCA. People were not always consulted in regard to their care and support. For example, a person's care plan stated the outcomes the person would want to achieve, would be up to the person's parent. However, the person had capacity to make some of

those decisions for themselves.
● People had been asked for their preference regarding mask wearing by staff. Whilst the decisions were recorded for all people living at the home, no steps had been taken to maximise people's ability to participate meaningfully with the decision-making process. For example, there was no reference to whether people had capacity to make this decision and people's communication needs had not been considered. This meant people were not meaningfully enabled to give their consent for staff to wear or not wear masks when they were being supported.
● Legal authorisations were in place or had been requested to deprive a person of their liberty.

Preventing and controlling infection
● We were somewhat assured that the provider was using PPE effectively and safely. We observed some members of staff wearing masks around their chin which was not in line with the provider's policies and processes. We also observed some members of staff wearing PPE in communal areas, prior to supporting people with personal care.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. We identified a lack of cleaning, in areas in the home, which the governance systems in place had not identified, and a lack of effective security of hygiene waste. Areas where a lack of cleaning were found were shared with the provider, who told us they were unaware of the lack of cleanliness issues found as they had not checked the areas for a long time.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● 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.

Visiting in care homes
● Visiting was in line with the government's latest guidance and there were no restrictions at the time of our inspection.
● During COVID 19, the provider did enable people to visit the people living in High Mount in line with government guidance by the use of a pod building in the grounds. This building had two rooms separated by a large window which were heated and furnished for people to see their loved ones, friends and professionals.

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 our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed 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.

At our last inspection the provider had failed to ensure effective governance was in place to deliver high-quality, person-centred care. This placed them in breach of regulation 17 (1) of the Health and Social Care Act 2008.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care

- Systems in place to assess, monitor and improve the quality and safety of the service were still not effective. People's personal information was not stored securely. The Local Authority had told the provider to keep people's information safe from unauthorised access. The provider did not do this and so failed to protect sensitive information.
- Weekly care audits were completed but effective actions were not always taken to address issues and make changes to safeguard people's health and well-being. We found 1 person required a set amount of fluid every day. Daily records showed the person did not receive the amount they needed, and this was identified by the weekly care audits. However, no effective action was taken to address this, so the person was placed at continued risk of dehydration.
- People's care plans were audited regularly but failed to identify that changes in need for people were not always recorded, risk records were contradictory, and risk was not always monitored and escalated where needed, to safeguard people's health. Audits identified assessments of need for people were not being completed to ensure the service had up to date accurate information for people. No effective action was taken to ensure the assessments were completed. This meant people were at risk of harm as the service did not always have up to date information to meet people's needs and monitor and minimise the risk of harm.
- Audits were in place to monitor the environment, but we found risks were not always identified, such as insecure hygiene waste, hazardous substances being accessible and staff handbags left in communal hallways. On our last inspection we observed a person who was identified as at high risk of choking, accessing a staff handbag seeking food. On this inspection we saw three staff handbags in a communal hallway in the same building. The manager could not provide assurance there was nothing of risk in the handbags and they were removed and placed in a secure location. The provider failed to assess the risk of the staff handbags still being accessible and did not take reasonable steps to ensure they were stored securely to minimise the risk of harm.
- Equipment used in the service was not always checked regularly. Audits identified this, but no effective

action was taken to ensure all equipment was checked regularly to ensure it was safe to use. For example, weekly monitoring of assisted aids, mattresses, sensors, and call bells identified that staff were not completing regular safety checks. This put the people living in the service at increased risk of harm from equipment that may have been faulty or unsafe.
Systems in place did not always effectively assess, monitor and mitigate risk relating to the health and safety and welfare of service users to improve the quality and safety of the service provided. This placed people at risk of harm. This was a continued breach of Regulation 17 (1) and a breach of Regulation 17 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The culture in the home did not always support person-centred care. We observed lower staff numbers supporting people in the service than we were told, were required to meet people's needs. This meant care became functional and task orientated rather than empowering and enabling. For example, we observed staff choosing what programmes were being shown on the television, without asking the people being supported what they would like to watch, when staff were preparing lunch.
● Staff did tell us they liked working in the service, enjoyed supporting people to access activities such as shopping and snooker and told us "It's seeing the guys happy, even if it's just going to Asda for lunch"

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, Working in partnership with others
● Health professionals told us they had experienced some historical issues in obtaining comprehensive health information from the service when working with individuals and told us "Information from the service can vary from different staff". Due to these concerns, the service had been asked to submit written health monitoring documentation. The documentation submitted was reported, as not always completed, which had to be sent back to the service to remedy. This meant effective monitoring by health professionals was delayed by incomplete documentation.
● Relatives told us the provider was proactive in involving them in the service. One relative told us they were unable to visit the service but kept in regular touch via telephone "They're fantastic, keep in contact, keep me up to date with what's going on". Another relative told us they visited their relative regularly and told us "I think the home is absolutely fabulous".

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 told us they understood their responsibilities to be open and honest with people when things went wrong under the duty of candour regulation.

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<br><br>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |

**The enforcement action we took:**

Warning Notice issued on 16 May 2023 requiring the provider to become compliant by 07 August 2023.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17 HSCA RA Regulations 2014 Good governance |

**The enforcement action we took:**

Warning Notice issued on 16 May 2023 requiring the provider to become compliant by 07 August 2023.