Crosscrown Limited

Highfield Residential Home

Inspection report

The Common
Marlborough
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Highfield Residential is a residential care home providing accommodation and personal care to up to 26 people. The service provides support to people aged 65 and over, and people living with dementia. At the time of our inspection there were 9 people using the service. The service currently accommodates 9 people in 1 building, across 3 floors. There is a communal lounge, a dining area, and a large garden area.

People's experience of using this service and what we found
People were not always supported safely. Systems and processes were not always in place and effective in managing risks to people. We found that allegations of abuse were not always responded to appropriately, leading to a poor culture within the service. There was a lack of training for staff.

People were not always supported in a person-centred way. We observed interactions where staff did not respect people's equality and diversity. People were not always offered choices. Relatives gave mostly positive feedback, although some raised concerns around lack of engagement and activities for people.

We identified concerns around the culture of the service during our inspection, in terms of the way staff supported people and the way the service was run. There was a lack of quality monitoring and support for staff.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. We saw that many people living at Highfield had sensor mats, to alert staff when a person stood up and to reduce the risk of falls. There was no evidence of any mental capacity assessment or best interest decisions relating to these at the time of inspection.

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 1 April 2019).

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

Why we inspected
The inspection was prompted in part due to concerns received about the culture of the service. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led only.

The overall rating has changed from Good to Inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, caring 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 and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to the safety of people using the service, managing risks, good governance, personalised care, and consent for people. We have issued two warning notices to ensure the provider makes improvements.

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 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.

Special Measures:
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.

If the provider has not made enough improvement when we re-inspect 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.

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.

Is the service caring?

Requires Improvement

The service was not always caring.

Is the service well-led?

Inadequate

The service was not well-led.

Highfield Residential 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 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 and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Highfield Residential 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. Highfield Residential 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 not a registered manager in post. A new manager had been in post for 3 months but had not submitted an application to become the registered manager. We recommended that the manager applies to register as soon as possible.

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 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 used all this information to plan our inspection.

During the inspection
We spoke with 3 people living at the service, 5 relatives, 4 care staff, a kitchen assistant, activities co-ordinator, and the manager. 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. We reviewed a range of records. This included three people's care records, daily records and medication records. We looked at 3 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.

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 good. 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 did not always have up to date risk assessments and the manager did not have oversight of individual risks, such as risk of falls. As a result, falls occurred regularly with little, or no action taken to mitigate future risk.
- Systems for responding to accidents, incidents and near misses were not always effective. We found 1 person had 7 falls in 6 months before any action was taken and a risk assessment completed.
- Staff did not know how to respond to protect people in the event of a fire. The last fire drill took place in 2021. One staff member told us they "would know to call the fire brigade and go to fire box, but other than that don't really know [what to do]". Another staff member told us they would go to the car park if the alarm sounded.
- The provider had not taken action to protect people from the risk of fire. We saw urgent actions stated in the home's fire risk assessment dated June 2022 which had not been completed until a year later in June 2023, such as bolts on fire doors needing to be removed. The potential consequences of fire within the home were assessed to be extreme. The provider responded to these concerns on inspection and has now taken action.
- The service did not effectively manage the risk of scalding from water outlets. Water temperatures were measured monthly, however temperatures of hot taps in people's rooms and shower rooms were regularly above safety guidelines of 44 degrees Celsius, some reading as high as 62 degrees Celsius. This put people at risk of scalding. We raised this with the manager who informed us thermostatic mixing valves were being installed to address this risk, however temperatures had been consistently outside of recommended ranges for at least 6 months.
- The service had environmental risk assessments that had not been recently reviewed, such as environmental activities and infection prevention control. This meant people were at risk of harm relating to the environment, as new hazards may not have been identified and control measures may not have been put in place.

Systems had not been established to assess, monitor and mitigate risks to people ensuring their safety. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Mental capacity

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)

● We found the service was not working within the principles of the MCA. People at risk of falls had sensor mats in place, which alerted staff when people stood up. There was no evidence of any mental capacity assessments or best interest decisions at the time of inspection, to assert if this was the least restrictive option. The provider has now taken action and has updated MCA's in relation to sensor mats being used.

● Appropriate legal authorisations were in place to deprive a person of their liberty. However, these did not reflect the current restrictions to people's freedom. For example, there was no mention of sensor mats in people's DoLS.

● Staff were not trained in mental capacity. We noted practices where the mental capacity act was not followed. We observed staff cutting a person's food halfway through their meal, without asking their consent, and staff telling a person they would need to go to the dining area for lunch after they had requested to stay where they were sat.

The service did not always work within the principles of the Mental Capacity Act 2005. This was a breach or Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Not all staff had been trained to recognise and respond to the risk of abuse. Some staff raised concerns about the lack of training; one staff member told us they had worked at the service 3 years and had not received any training in safeguarding adults.

● The management team did not respond to safeguarding concerns swiftly to protect people from the risk of harm. One staff member told us they raised a safeguarding concern which took 7 weeks to be actioned. We saw evidence of this during our inspection. This meant people were at risk of abuse.

● We were told of a poor culture within the service. One staff member told us they were not offered further shifts at the service after they had raised safeguarding concerns.

Systems had not been established to assess, monitor, respond and mitigate the risk to people from potential abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff had not received regular supervision. One staff member did not know what a supervision was when asked. This appeared to have an impact on staff culture and morale. The manager told us supervisions were now taking place.

● There appeared to be enough staff to support the current number of people living at the service, however staff were not equipped with the necessary skills, training required to support people in an effective way.

● The provider adopted safe recruitment practices, such as undertaking Disclosure and Barring Service (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.

Using medicines safely

● Medicines when required (PRN) protocols were out of date and needed to be reviewed. This placed people at risk of receiving medicines which did not meet their current needs.
● We were not assured medicines were stored at safe temperatures. The temperatures of cabinets were not always taken. This increased the risk of medicines losing their effectiveness due to temperatures being stored outside of the recommended range.
● Medication administration records showed medicines had been signed for. However, stock checks were not always taken on non-blister packed medicines. This increased the risk of error as it was not always clear medicines had been administered to people .
● We saw that there were 3 staff trained in medicines, and that one person was currently being trained. Staff told us they had some concerns about lack of medicines training for night staff. The staff told us; "There isn't always a medicine trained member of staff on shift at night, if there was an issue I'd call someone".

Systems and processes were not always in place to ensure medicines were managed safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Controlled medicines were managed safely. Stock tallied with what was recorded in the controlled medicines book.

Preventing and controlling infection
● 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 using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● 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 were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● We were assured the provider was facilitating visits for people living in the service in accordance with the current guidance. The staff at the service recorded information according to visiting rules before the inspectors could enter the premises.

Learning lessons when things go wrong
● Safety concerns in relation to individual risks, fire safety and hot water were not consistently identified or addressed in a timely way, and there was limited evidence of learning from events or action taken to improve safety .
● We saw policies and procedures were updated in response to a safeguarding concern, but this was not effective. The policy around staff internet usage and mobile phones stated; "It is policy that under no circumstances, members of staff use or carry mobile phones on their person when on duty". We observed one staff using their personal mobile phone during inspection.
● Staff did not feel allegations of abuse would be responded to in an appropriate way and raised concerns about managements' response to concerns.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
●People were not always treated within the principles of equality and diversity. One person told us "I'd like to go shopping – I don't get the chance to do that". We did not see any evidence of community access during our inspection.
● Staff did not always engage with people using the service. People were left for long periods of time without interaction from staff. At times staff would enter the room without acknowledging people.
● Daily notes were task-focused and not person-centred. There was minimal detail in daily records about how people were each day and how they were supported.

The service failed to support people using a person-centred approach. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed some positive interactions with staff. We observed some staff offering people choices and speaking to people kindly.
● Relatives were happy with the care provided by staff. Comments included "[We are] thoroughly happy. We have peace of mind knowing [person] is being well looked after".

Supporting people to express their views and be involved in making decisions about their care
● People were not always involved in decisions relating to their care. For example, people did not have regular reviews relating to their care and treatment. The manager told us they were in the process of reviewing care and support documentation and that they will "try to involve family, next of kin and the [person]". We did not see any evidence reviews were taking place during our inspection.
● Staff were polite to people when supporting them, but this was not always person-centred. We observed one person being supported to sit in the living room, staff left and did not ask the person if they would like to watch anything on the television or do any activity. The same person expressed they would like to stay in their new seat as long as possible, staff told them they would have to get up in half an hour to go to the dining room for lunch, staff did not offer the person to have lunch in their current seat or an alternative lunch arrangement.
● Staff told us people have a choice in meals each day . Comments included; "Daily we go around and ask [people] what they would like, there are two options of main course, three vegetables, desserts is always one hot and two cold, evenings there is a choice of two supper dishes". During inspection we observed one person asking what was for lunch. Staff replied "everyone has got jacket potatoes". The person was not asked if they were happy with this or if they would like an alternative meal.

The service failed to consistently involve people in decisions about their care. This was a breach of Regulation 9 (Person-centred care) and Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

● We were not assured people's privacy, dignity and independence was respected. We observed interactions from staff which did not promote this. For example, we observed staff putting aprons on people half way through their meal, staff did not always ask for consent to do so.

●People did not always talk about people respectfully. We heard one member of staff describe someone as a "baby" as they just "eat, sleep and go to the toilet". Most staff had not completed training in equality and diversity. We observed the impact of the lack of training in the way people were supported.

● When asked if staff treat them with dignity and respect, a person told us "No they often forget about me. They never come into my room and do things because they know… I can do them". Another person we spoke to felt their privacy and dignity was respected.

The service failed to consistently promote people's privacy, dignity and independence. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 good. 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.

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

- There was a lack of meaningful audits and checks carried out by the manager and the provider, leading to a service which put people at significant risk of harm and a decreased quality of life. For example, health and safety audits had not effectively identified that water outlets were above recommended temperatures for 6 months, posing a high risk of scalding to people.
- The management and leadership within the service was inconsistent. The home had been without a registered manager for some time. The current manager was unaware of any plans to become registered with the Commission.
- Staff felt unsupported by a lack of management structure. One staff member told us they "felt like [the provider] forgot about Highfield, we had [area manager] in for a period of time and had two seniors in place. One of them has since left. People felt forgotten about".
- The manager was not aware of all risks to people, such as falls, and where some key and current information was held, such as people's up to date care and support plans. The manager had been in post for 3 months at the time of inspection.

Governance systems failed to monitor quality and safety within the service. This was a breach of Regulation 17 (Good governance) of the Health and Social care Act 2008 (Regulated Activities) Regulations.

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

- Management failed to ensure staff were suitably skilled, trained and supported to meet the needs of people living at the service. For example, staff supported people with end-of-life care and dementia. Three staff we spoke with confirmed they had not received training in these areas and records confirmed this. This placed service users at risk of being supported by staff who did not have training relevant to service users' needs.

'The service did not always ensure staff received the appropriate support, training, professional development and supervision to enable them to meet all other regulatory requirements described in this part of the Health and Social Care Act 2008. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Most staff we spoke with raised concerns about the culture of the service. Staff felt incidents were not

taken seriously, and we observed this during inspection.
● The service was task-focused and care was not always person-centred. There was no evidence of people achieving good outcomes . For example, daily notes referred to food, drinks and personal care given but did not contain any detail about how people were supported.
● There was not an open culture. Staff were not assured that safeguarding incidents would be investigated appropriately, and as a result The Commission received various whistleblowing concerns about the culture of the service.

The provider did not ensure systems and processes were established and operated effectively to ensure the safe running of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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
● Notifications had not always been sent relating to allegations of abuse. Safeguarding incidents had not always been investigated promptly and appropriately, leaving people at risk of harm.

The service had failed to notify CQC of all incidents that affect the health, safety and welfare of people who use services in a timely way. This was a breach of Regulation 18 (Notification of other incidents) Care Quality Commissions (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We were not assured people had been sufficiently involved in decisions relating to their care. Relatives told us they had been involved in care and support plans when their relative moved to the service, but had not been involved in any care reviews since. Comments included, "We have not sat down and gone through a care plan" and "Nothing has changed so it has not been reviewed".
● Staff had been asked for feedback during staff meetings. We saw that there were two recent staff meetings on file.

Continuous learning and improving care; Working in partnership with others
● We saw the service worked in partnership with the local surgery and district nurses.
● There was little or no evidence of learning, reflective practice and service improvement. Records did not give a clear picture of incidents, triggers, or any analysis of learning to improve the service.

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 Registration Regulations 2009 Notifications of other incidents The service had failed to notify CQC of all incidents that affect the health, safety and welfare of people who use services in a timely way. This was a breach of Regulation 18 (Registration) of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service failed to consistently involve people in decisions about their care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not always work within the principles of the Mental Capacity Act 2005. This was a breach or Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

	Systems had not been established to assess, monitor and mitigate people from potential abuse. This placed people at risk of potential abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements described in this part of the Health and Social Care Act 2008. This was This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Systems had not been established to assess, monitor and mitigate risks to people ensuring their safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems failed to assess, monitor and mitigate the risks to people. This was a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations.

The enforcement action we took:

Warning notice