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Higham House Nursing Home

Inspection report

87 Higham Road
Rushden
Northamptonshire
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Tel: 01933314253

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Higham House is located in the town of Rushden in Northamptonshire and provides people with accommodation, personal care and nursing care. They are registered for up to 30 older people who may also be living with conditions such as dementia. On the day of our inspection there were 22 people living at the service.

We previously carried out an unannounced comprehensive inspection of this service on 1 March 2017 and identified six breaches of legal requirements.

We found that accidents and incidents had not always been reviewed appropriately to determine whether they should be raised as a potential safeguarding. This meant that not all incidents had been referred to the local authority for further investigation and that appropriate action was not always taken to keep people safe from abuse or neglect.

Risk assessments were not always reflective of people's current needs and did not always contain sufficient information to guide staff.

There was not always sufficient staff on duty, with the correct skill mix, to support people with their needs. Staff were only able to meet people's basic care needs but did not have the time to provide them with any meaningful support during peak times because of their deployment within the service.

Staff supervisions were not completed on a regular basis which meant that staff did not always have a record of formal discussions which took place. All staff said they felt well supported by the registered manager, who accepted that they needed to review the supervision system in place to bring this in line with the provider policy.

Although there were systems in place in respect of the Mental Capacity Act 2005 (MCA) these were not always used appropriately to ensure that decision specific assessments were completed for people.

Care plans did not always provide staff with sufficient guidance to meet people's specific needs and wishes and were often not user-friendly. Some aspects of the care plans had not consistently been reviewed and there was not always evidence to show that people or their families had been involved in reviewing them.

Quality monitoring systems and processes had not always been used as effectively as they could be to ensure that action was taken to make improvements when required. Audits failed to highlight key areas of the service in which improvements were required. There was a lack of management and oversight systems in place, which meant the registered manager and provider, were unable to monitor, assess and drive improvements at the service.

Following the inspection the provider sent us an action plan detailing the improvements they were going to

make, and stating that improvements would be achieved by 1 May 2017.

This report only covers our findings in relation to the outstanding breaches of regulation. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Higham House Nursing Home' on our website at www.cqc.org.uk.

This inspection took place on 3 May 2017 and was unannounced.

During this inspection, we found there was more robust oversight of accident and incident records. The registered manager now reviewed them to ensure they were reported as a potential safeguarding matter if appropriate.

We reviewed people's risk assessments and care plans to ensure they had been updated in accordance with any changes in their care needs, or general condition. Guidance for staff was more robust and detailed which aided them to better complete the risk assessments. We found that steps had been taken to review care records and associated risk assessments on a monthly basis so they remained reflective of people's care and support needs.

Staff numbers and staff deployment within the service had been reviewed to ensure that numbers were sufficient to keep people safe and enable them to have their needs met in a timely manner.

Action had been taken to review people's mental capacity, in line with the Mental Capacity Act 2005 (MCA) and where appropriate, we found that decision specific mental capacity assessments had been completed, utilising appropriate professionals to ensure a robust decision making process had taken place. We also found that staff had worked to document people's consent to care and treatment.

Quality assurance processes had been reviewed and we found that the registered manager now had more oversight of the areas where there had been previous breaches of regulation. They now had an action plan by which they would review each area to ensure they remained current and reflective of the situation within the service.

While improvements had been made we have not revised the rating for the four key questions inspected; to improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for safe, caring, effective, responsive and well-led at the next comprehensive inspection.

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

We found that action had been taken to improve the safety of the service.

The systems and processes in place in respect of monitoring safeguardings had been strengthened.

Risk assessments had been reviewed and improvements made to the guidance for staff to follow. We found they were now more robust, detailing specific needs which people might encounter.

Staffing had been reviewed and numbers were sufficient to meet people's needs. A more formal dependency tool was now being used to ensure numbers of staff remained suitable for the amount of people in the service.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require consistent good practice over time. We will review our rating for safe at the next comprehensive inspection.

Is the service effective?

Requires Improvement

We found that action had been taken to improve the effectiveness of the service.

A formal schedule had been implemented so that staff could receive more regular supervision.

The systems in place to ensure people's mental capacity had been formally assessed, had been reviewed and applied more robustly.

We have not changed the rating for this area, although some improvements have been made. To improve the rating to 'Good' would require consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service responsive?

Requires Improvement

We found that improvements had been made to the responsiveness of the service.

Care plans had been reviewed and updated so that they were more person centred and reflective of people's current needs.

We have not changed the rating for this area, although some improvements have been made. To improve the rating to 'Good' would require consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

We found that action had been taken to improve the management of the service.

The registered manager had acted upon those areas of improvement we identified during our last inspection. We found evidence of more formal oversight and on-going monitoring taking place.

Because of this strengthening in the quality assurance systems, we observed an improvement to the way in which records were managed, monitored and updated.

We have not changed the rating for this area, although some improvements have been made. To improve the rating to 'Good' would require consistent good practice over time. We will check this during our next planned comprehensive inspection.

Higham House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 May 2017 and was unannounced. The inspection was undertaken by one inspector.

Prior to this inspection we reviewed all the additional information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law.

During our inspection, we observed how staff interacted and engaged with people during individual tasks and activities. We spoke with three people who used the service to determine if they had noted any improvement since our last inspection.

We spoke with the registered manager, two nurses and one member of care staff. We also spoke with a representative of the local authority and clinical commissioning group to gain their feedback as to the care that people received.

We looked at four people's care records to see if they were accurate and reflected their current needs. We reviewed four weeks of staff duty rotas, training records and further records relating to the management of the service, including quality audits. This was with the intention of ensuring that the service maintained a robust oversight of the delivery of care.

Requires Improvement

Is the service safe?

Our findings

During our inspection on 1 March 2017, we identified that systems and processes were not operated effectively to ensure that people were protected from potential abuse. When we reviewed accident and incident records we found that not all potential concerns had been reported to the local authority or the Care Quality Commission (CQC), once staff had completed an incident report. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found that the shortfalls in relation to the regulatory requirements as described above had been addressed. The registered manager told us, and records confirmed that they had compiled a log of all accidents and incidents which detailed the action taken. In this way, they could maintain a robust oversight of all concerns, and document whether the incident had been referred to the local authority as a possible safeguarding matter. This log would be maintained on a month by month basis and used to analyse whether particular patterns or triggers existed. Safeguarding alerts had been raised appropriately when appropriate.

During our inspection on 1 March 2017, we also identified that the systems in place for assessing risk factors for people were not robust. Risks around people's needs were not always recognised or appropriately assessed. As a result of this, the care and support provided to people could have been compromised. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found that the shortfalls in relation to the regulatory requirements as described above had been addressed. One staff member told us, "The risk assessments have improved, they are much better now. They give us more guidance and make things clearer. We have all the information we need now." The registered manager told us that the staff had worked hard to review all risk assessments and improve the content so that people were kept safe. Records showed that risk assessments were more up to date and reflective of people's current needs.

During the inspection on 1 March 2017, we observed that there were not sufficient numbers of sufficiently skilled staff on duty to provide people with care which met their assessed needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found that the shortfalls in relation to the regulatory requirements as described above had been addressed. People told us they thought that there were enough staff on duty. One person acknowledged that there were more staff present at peak times, for example meal times. Staff told us how they felt staffing levels and general deployment had improved since our last inspection. We heard how recruitment had taken place, with more nursing staff being employed. The registered manager discussed how they now used a formal dependency tool for each person who lived in the service. They hoped to expand on this this and find a method of using the information to ensure that staff ratios remained appropriate at all times. On the day of our inspection, we saw that there were sufficient staff on duty, with there being a contingency plan to deploy staff where they were needed at peak times, for example meal

times. Staff were now able to meet people's needs in a timely manner.

Requires Improvement

Is the service effective?

Our findings

During the inspection on 1 March 2017, we found that staff members were not consistently provided with sufficient supervision to ensure they had the knowledge, skills and support to perform their roles. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found that the shortfalls in relation to the regulatory requirements as described above had been addressed. Staff felt well supported by the registered manager and able to seek support when this was required. One staff member said, "I really do feel supported here." The registered manager showed us how they had formulated a schedule to ensure that they kept on track with staff supervisions and appraisals. We also saw how some supervisions would be delegated to appropriate staff for completion, which would enable them to be kept up to date. Improved systems had been implemented to ensure that staff received appropriate support.

During the inspection on 1 March 2017, we found that people's consent to their care and support was not consistently sought by the service. Care files lacked signed consent forms to demonstrate that people, or another responsible person such as a family member, had given their consent to the content of those files or for their photograph to be taken as part of the records. Where people were unable to consent or make decisions about their care, the principles of the Mental Capacity Act 2005 had not been adhered to. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found that the shortfalls in relation to the regulatory requirements as described above had been addressed. Staff told us how they had worked hard to update individual mental capacity assessments and records confirmed this to be the case. Nursing staff and the registered manager told us how they had reviewed all aspects of care which required a mental capacity assessment. The registered manager told us, "My staff have worked really hard to make the assessments more detailed and completed for the right reasons."

We saw more evidence of decision specific capacity assessments having taken place. These were for issues such as personal care and medication, but also included Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR.) Each one had been completed in detail in association with relevant professionals and appropriate representatives. Action had been taken to improve the systems in place for assessing mental capacity.

Requires Improvement

Is the service responsive?

Our findings

During the inspection on 1 March 2017, we found that people's care plans had not always been updated in respect of their current care needs. Care and treatment of people living at the service did not always reflect their preferences or meet their specific needs. Care plans were not person-centred. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found that the shortfalls in relation to the regulatory requirements as described above had been addressed. Since our last inspection, staff had worked hard to ensure that each person's care plan had been reviewed and updated so that they contained information and guidelines that were up to date. One person told us how they had been involved in the process of ensuring their care was right for them. Another person when asked about if they knew about their care plans, said, "Yes, I see them writing about me." People had been involved, where appropriate, in compiling their care plans to ensure they met their needs.

We reviewed records and found that they were more person centred, and had taken into account people's likes, dislikes and preferences. We saw that the process of review had involved the person and their relatives where appropriate. Staff were keen to tell us that they wished to continue to improve this process and wanted to further develop the care plans used to ensure they were the best they could be.

Requires Improvement

Is the service well-led?

Our findings

During our inspection on 1 March 2017, we identified that the systems in place for monitoring record keeping and ensuring that people's individual records were up to date were not used effectively. Care records and risk assessments had not consistently been updated which meant they were not always reflective of people's current needs. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found that the shortfalls in relation to the regulatory requirements as described above had been addressed. Staff told us that since our last inspection, they had ensured that people's care records were updated on a regular basis. Each person's care records had been reviewed and changes made to them, in conjunction with family members and professionals to ensure they were reflective of people's current needs. We could see that actions had been taken to review people's care records and evaluate them on a regular monthly basis.

The registered manager told us that they had formulated a system where they could review and monitor each area of concern we had identified during our last inspection. Staff were to be given areas of interest, for example medication and care plans, which would be overviewed by the registered manager. In this way, there would be more managerial oversight of all quality assurance systems and processes. We also heard how the quality satisfaction questionnaire was to be reviewed so that more formal analysis could take place.

Care record audits now took place and we found that where issues had been identified, action plans were formulated with specific time scales in place for action to be taken. Improved systems and processes had been implemented so that the service could move forward and deliver quality care. It was evident from our discussions with staff and the registered manager how they wished to learn lessons from their last inspection and make improvements that could be sustained in all areas.