

The Heights Care Limited

The Heights Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

The Heights Care Home is a residential care home providing personal and nursing care to 29 people aged 65 and over at the time of the inspection. The Heights Care Home can accommodate up to 33 people in one adapted two-storey building.

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

Infection prevention and control practices were not of an acceptable standard. The premises were generally tired and worn. A home improvement plan was in use in the home. The aim of the plan was to record issues in the home and the action planned to address these issues, by when the issues would be addressed and by whom. This information was not always recorded in the plan. The manager and staff responded quickly to some of the issues identified during the inspection.

Risks to people were mostly identified and managed. Care plans included clear guidelines for staff to follow to best meet a person's needs. People's medication was managed and administered safely. Staff followed guidelines for the safe use of personal protective equipment (PPE) and supplies of PPE were plentiful.

Complaints, concerns and compliments were addressed when received.

People were supported by staff who knew them and experienced positive interactions. People were involved in identifying their preferred activities. Staff supported people according to their individual preferences and facilitated people to make day to day choices. Care plans identified how people preferred to communicate. Resources were available for staff to use when supporting people whose first language is not English. Visiting procedures at the home followed current government guidance.

Care plans were person centred. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

This service was registered with us on 21 September 2020 and this is the first inspection.

The last rating for the service under the previous provider was requires improvement, published on 14 October 2019.

Why we inspected

The inspection was carried out to support the decision making process in response to the application for a new registered manager and to assess the quality and safety of the service.

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.

We have identified breaches in relation to keeping people safe from infection and good management oversight of the service at this inspection.

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

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was effective.

Details are in our effective findings below.

Good ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

Good ●

Is the service well-led?

The service was not always well led.

Details are in our well led findings below.

Requires Improvement ●

The Heights Care 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

The Heights Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The previous manager registered with the Care Quality Commission is no longer employed by the provider and is in the process of de-registering. The current manager is in the process of registering with us.

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 and professionals who work with the service. We used all of this information to plan our inspection.

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

We used all of this information to plan our inspection.

During the inspection-

We spoke with two people who use the service and five relatives about their experience of the care provided.

We spoke with eleven members of staff including the manager, the deputy manager, the clinical lead, nurse, care workers, the chef, laundry and maintenance staff.

We reviewed a range of records. This included five people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. This is the first inspection for this service since the provider changed on 20 September 2020.

This key question has been rated requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- Infection prevention and control measures did not fully adhere to best practice guidance and government requirements in managing the current COVID-19 pandemic.
- We were not assured the provider was promoting safety through the hygiene practices of the premises.
- People were at risk of cross infection from poor hygiene practices. Soiled equipment used for personal care was seen in communal bathrooms. One sluice machine was out of order, plans to replace or repair were not clear or known by staff. Soiled equipment was also found stored as ready to use in a second sluice area.
- Some areas of the service were difficult to clean due to their poor condition. This meant people were at increased risk of cross infection. Examples seen throughout the building included: damage to painted handrails, damaged flooring in bathrooms, soiled carpets and clutter.
- Safe hand hygiene practices were not assured. Facilities were not consistently available in staff areas. For example, one toilet had no water available at the sink as it had been shut off due to a thermostat fault.; the staff room did not have hand sanitiser gel available. As the room was in use there should be sanitiser gel available for staff to use. This meant people were at increased risk of cross contamination.
- The laundry room was cluttered and needed cleaning. Space was insufficient for storing the laundry trolleys, these were found to be in the corridor or in the bathrooms that people used. The laundry room sink was used for filling and emptying of buckets used by domestic and kitchen staff.

The provider had failed to mitigate risk in relation to infection, prevent and control. This placed people at risk of cross infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded immediately during and after the inspection to rectify some of the issues we made them aware of. During the inspection staff cleaned and secured an area of damaged flooring. After the inspection the manager removed rubbish; had the laundry room cleaned and had repairs made to handrails. Following feedback, the provider arranged a quality audit visit of the home.

- Other areas of preventing and controlling infection were in place and we were assured in these areas.
- 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 the provider was facilitating visits for people living in the home in accordance with the current guidance.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider's infection prevention and control policy was up to date.
- One staff member we spoke with told us they had completed training in relation to COVID-19, felt safe in the home and had plenty of PPE available. Relatives we spoke with also told us they felt safe when going into the home.

Systems and processes to safeguard people from the risk of abuse

- People were supported by staff who told us they understood how to keep people safe. Staff had completed safeguarding training to identify and respond to safeguarding issues. One staff told us, "I am confident concerns I have raised are dealt with by the management team".
- Incidents were recorded, reported and processed. The manager analysed these reports and shared information appropriately, for example, with the local authority and Care Quality Commission (CQC). Risk assessments and care plans were updated in response to incidents and changes made known to staff. One relative we spoke with told us, "My relative is safe here and well looked after".

Assessing risk, safety monitoring and management

- People's risk assessments were completed, and the information used to develop individual care plans. Staff were aware of and understood the changes to people's care plans and were able to implement these. One staff member we spoke with told us, "Staff are aware of the risks and know how to keep people safe".
- Individual risk assessments had been completed for the safe evacuation of people in the case of a fire in the home. These were easily accessible in people's files for use in an emergency.

Staffing and recruitment

- People were supported by staff who were suitable to work with vulnerable people. The recruitment policy and procedure followed safe recruitment guidelines. Staff were employed after appropriate checks were made.
- There were enough suitable staff deployed to provide safe care and treatment for people. Staff told us staff numbers were enough on each shift to support people's planned care. Contingency measures were in place to cover short notice absences such as sickness. For example, bank staff, agency, management and extra hours were used to cover if needed.

Using medicines safely

- People were supported safely to take their prescribed medication. Policies and procedures relating to medication were up to date and followed relevant NICE guidelines. The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. Staff were trained and competency checked to administer medication.
- Audits were completed monthly of the medication procedures to identify and address any issues.
- People received 'as required' medication safely. Protocols for 'as required' medication were clear and described when medication could be administered. Care plans included how people communicated their need for 'as required' medication to be administered. For example, how one person asked for pain relief through facial expression.
- One person received their medicines covertly. Covert administration is when medicines are administered in a disguised format. The person took their medicines crushed and added to food. The guidelines for administration were clearly written for staff to follow. Procedures were followed where people lacked capacity and needed medicines to be administered covertly. The appropriate forms were filed, completed

and reviewed by the GP.

Learning lessons when things go wrong

- Incidents were reviewed by the manager and updates made to risk assessments and care plans.
- Records of concerns, compliments and complaints were made. Relatives and members of staff we spoke to were happy to raise any concerns they had and were confident that issues would be addressed.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this service since the provider changed on 20 September 2020. This key question has been rated good.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

Adapting service, design, decoration to meet people's needs

- People were able to use adapted equipment to have a bath or shower when they chose. For example, accessible baths and showers, hoists and aids.
- People were able to personalise their own rooms with their own furniture and belongings. People were supported by staff to use their own room as they wished. People chose to spend time in their rooms doing their preferred solo activities.

Staff support: induction, training, skills and experience

- People were supported by staff who had the necessary skills and knowledge. Staff completed the organisation's induction and training programme. Staff worked alongside experienced staff for a period of supervised practice as part of their induction.
- Staff were able to identify risks for people and knew how to manage them, for example, falls. One staff member told us "I feel confident I know how to look after people". One relative we spoke with said "Staff do their job well; staff know how to look after mum".
- Staff supervision and appraisal meetings with a manager were scheduled to take place. Records showed performance objectives were discussed and managed.

Supporting people to eat and drink enough to maintain a balanced diet

- People's nutritional risks were assessed and monitored using a nationally recognised screening tool, the MUST nutritional assessment form. Staff we spoke with told us the tool was reviewed monthly, this was evidenced in the individual care records we reviewed. Changes in people's needs were identified and acted on. The tool had been used to check people were eating and drinking enough.
- People's meals were provided to meet their individual nutritional needs. Staff in the kitchen understood people's individual requirements. Meals were offered to meet people's needs, this included high calorie foods.
- People were offered a choice of food at mealtimes as well as where and when they ate. People told us they liked the food on offer and the meals looked appetising.
- We saw there were enough staff to provide one to one support to people who needed help to eat their meals safely. Care staff understood people's individual dietary needs and made records of what people ate and drank.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support

- People were referred to the GP practice as required to meet their health needs. Visits took place weekly to assess and review people's medical care. Staff were kept informed and updated of changes in people's needs by daily meetings, handover records and care notes.
- People were referred for specialist assessment when needed, for example, speech and language therapy, dietitian and physiotherapy. Professional assessments were completed, and recommendations made. Guidelines for staff to follow were in people's care files.
- One relative we spoke to told us "It is not an easy job that staff do, it can be difficult, but they support (person's) needs very well". Another relative we spoke with told us, "Staff go over and above, it is out of this world what the staff do, it is like a family."

Ensuring consent to care and treatment in line with law and guidance

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 Act 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 MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DOLS).

- Capacity assessments had been completed where required. Best interest decision records were in care plans and showed who had been involved in making decisions on behalf of the person who was assessed to not have capacity to do so for themselves. For example, where medicines were to be administered covertly. One relative we spoke with told us, "I feel involved, I speak to staff and the manager regularly".
- A tracker was used by the manager to record dates of DOLS applications and outcomes and updates. Staff understood the procedure and how to support a person through an assessment and with a DOLS in place.
- People were involved in making day to day choices with support from staff, for example, where to spend their time, what to eat and what activities to engage with. People's care plans contained guidance for staff to understand how people made their choices known.

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

This is the first inspection for this service since the provider changed on 20 September 2020. This key question has been rated good.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were supported by staff who knew them well. We saw positive interactions between people and staff that were caring and kind. One member of staff we spoke with told us, "Getting to know people is my favourite part of the job". A relative we spoke with told us, "(person) is happy, staff know them and how to look after them".
- People were treated with dignity and respect by staff. Staff offered compassionate support to people at times when they felt anxious or distressed. One relative we spoke with told us, "Staff are really good with (person), [name] goes the extra mile, they really care." Another relative we spoke with told us, "(Person) tells me all the staff are lovely".

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- Staff supported people to make day to day decisions. Care plans included guidelines for staff to follow to support individuals to be involved in making decisions. People were offered choices by staff regarding meals and personal care and activities.
- People's privacy and dignity were respected. One relative we spoke with told us "I heard staff talking to my family member when they were supporting them, they were very kind and respectful, they told them they looked beautiful. I feel very comfortable that (person) is living here".
- Staff demonstrated they understood how to communicate with people in every-day situations, for example, at mealtimes people were supported to eat their meals at their preferred pace and were not rushed.
- People were able to receive visitors at the home following current government visitor guidelines. Staff were available to support people to receive visitors in their own rooms. One relative we spoke with told us, "It feels like it is their own home when I visit, they are very happy here."

Is the service responsive?

Our findings

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

This is the first inspection for this service since the provider changed on 20 September 2020. This key question has been rated good.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs (AIS)

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.

- Care plans were personalised to meet people's needs. People's sensory impairments were identified and clear guidelines for staff to follow to involve people in their every-day care. Care records completed by staff included choices made by people, for example, choices made during personal care.
- Resources were developed for staff to use to support communication with people whose first language was not English. A phrase book had been developed to make communication easier between one person and the staff member. This had been updated and in response to the person's changes in need to support ongoing effective communication.
- One relative we spoke with told us, "Staff don't just do the usual routine things, if my family member asks for something, even just a drink or a banana, they get them one." Another relative said "Nothing is too much trouble for them (staff)."

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

- People were supported to identify what they liked and disliked and activities they preferred. The service employed an activity coordinator who worked with people individually and recorded their preferences. Activities were arranged for individuals and small groups to encourage relationships developing within the home.
- People's activities were reviewed as their preferences were known. When it was identified that people would like to participate in more activities staff worked with people and their relatives for this to happen. For example, a person who liked to go out walking did so regularly with their family and staff. The garden was being worked on to be made safer for people who wished to access the garden more frequently.
- Visits from relatives were supported as per current guidance. One relative we spoke with told us, "Activities are always seen to be happening when I visit." Another relative told us, "We get a newsletter which is very informative, we can see staff are trying to do monthly activity events again."

Improving care quality in response to complaints or concerns

- Complaints and concerns were logged by the manager and addressed. Relatives and staff consistently

told us they felt comfortable to raise any concerns they had. Questionnaires were used by the manager as a method to get feedback from people, relatives and staff.

- Complaints about the quality of food offered by the kitchen were addressed quickly by the manager. One relative we spoke with told us, "The kitchen runs really well now, and the food is good."
- Another relative told us "The new manager has made improvements; the new furniture is good." A staff member we spoke with told us, "There have been lots of changes since the new manager came, all good."

End of life care and support

- A pathway was used to plan with a person and their family and record their preferences relating to end of life care. Anticipatory medication was seen to be made available for this event with the necessary authorisation by the GP.
- A relative we spoke with told us, "Staff were very good with my family member when they died here. I have no qualms about other family members being here."

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.

This is the first inspection for this service since the provider changed on 20 September 2020. This key question has been rated 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; Continuous learning and improving care

- The registered manager was no longer employed by the provider and was in the process of de-registering. The provider had appointed a new manager. They had begun the process to be the registered manager. We continue to monitor this.
- Opportunities to improve outcomes for people were missed as the manager did not implement an effective system for identifying health and safety issues in the home. We identified a number of issues and these were brought to the attention of the manager, some were addressed. For example, where a door strip was missing at a bedroom doorway the area was immediately cleaned and made safe to reduce the trip hazard; rubbish outside the front door was removed; arrangements were made for the removal from the car park of an open clinical waste skip. These issues had not been identified by audits carried out in the service.
- The manager implemented a checklist to be used daily to identify risks and issues in the home. Records failed to identify some issues we identified such as trailing cables in people's rooms; soiled equipment; broken equipment awaiting repair or replacement; documentation left in communal areas. This meant the system was ineffective to identify and take action to prevent potential risks to people and staff in the home.
- The manager did not act on all the findings and feedback from professionals advising where improvements could be made. For example, the IPC team visited in January 2021 and reported finding stained commode buckets in the sluice room and in a person's room. We still found soiled commode buckets and bed pans at this inspection. This meant people were at risk of cross contamination due to poor hygiene practices.
- The manager lacked accountability in taking the lead to improve the service. A copy of the home improvement plan was in place. However, it was not fully completed or updated by the manager or the provider. A more up to date version was made available after feedback but there was no evidence the manager had worked with the provider to develop or agree the plan.
- Communication between the manager and provider was not robust, for example, issues were not communicated to the provider to seek timely resolution, such as the improvements to the environment.

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

- The manager did not provide guidance to staff to ensure people's well being in extreme weather. The inspection took place on one of the hottest days of the year, recorded as 28 degrees Celsius. We identified

where people could be made more comfortable such as being offered cooled drinks and the use of fans. Drinks were readily available but did not feel cool to the touch and fans were in people's rooms but not switched on. Staff responded to our prompting for cooler drinks to be available and fans were switched on where people wanted them to be. Staff told us that there had been no directions from the manager on how to manage in the heat.

- People were at risk of receiving unsafe care and support due to audits being ineffective. Care plan audits were completed but did not identify all documentation missing from care plans. Some people's care plans were incomplete. For example, a personal emergency evacuation plan, (PEEP), was missing for a person who was recently admitted to the home; an individual activity risk assessment for a person was missing from their care plan. The missing PEEP and risk assessment documents were made available for review after informing the manager they were missing.

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 breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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; Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The manager understood their responsibility to share appropriate information with others, including the local authority and CQC. The manager had communicated regularly with the CQC, seeking support and advice.

- People, their relatives and staff told us the manager was approachable and accessible. One relative we spoke with told us, "I have the manager's number to call her anytime." A staff member told us "The new manager's door is always open."

- The manager received support from the provider to implement procedures in response to concerns raised by staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to mitigate risk in relation to infection, prevent and control. This placed people at risk of cross infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm.