Care Quality Commission

Castlemeadow Care Home (Halesworth) Ltd

Highfield House Care Home

Inspection report

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Ratings

Overall rating for this service

Is the service safe?

Is the service well-led?

Summary of findings

Overall summary

About the service
Highfield House Care Home is a residential care home providing accommodation for up to 40 people needing residential and dementia care in one adapted building. The service is arranged over two floors and a third storey referred to as a mezzanine. At the time of this inspection there were 32 people using the service.

People's experience of using this service and what we found
Our previous inspection in November 2019 found systems to monitor the quality and safety of the service had not been effective. Management and leadership had been inconsistent, and the culture created did not support the delivery of high-quality person-centred care. This inspection was prompted because we received information raising concerns about risks to people, poor care, insufficient staff and low staff morale. Our visit found frequent changes in managers had impacted on the quality and safety of the service. Failure to have a consistent manager in place had led to continued shortfalls in governance arrangements and risks associated with fire safety, medicines and people's welfare were not always being identified or managed. Where audits had identified improvements were needed, these did not reflect how issues were to be addressed and monitored to ensure the required improvements were made, by whom and by when.

We have made a recommendation about developing a robust system to assess and monitor the quality and safety of the service to drive the required improvements.

Fire systems and equipment were checked regularly, however, these had not identified the risks of locking gates to stairs, which were also fire exit routes. Although the area manager took immediate action to have the locks replaced with keypad locks which automatically release in the event of a fire, routine checks had not identified this risk.

People's prescribed medicines, including controlled drugs were not always stored, administered and disposed of safely in accordance with relevant national best practice guidance. People were at risk of harm where their medicines were not being administered accurately in accordance with prescriber instructions.

Improvements were needed to ensure risks to people were identified, and all reasonably practicable measures taken to reduce that risk, including but not limited to choking and pressure wound management. Poor record keeping was placing people at risk of not receiving the care and support they needed, such as ensuring they received adequate fluids to remain hydrated and repositioned to prevent pressure wounds developing.

Of the nine people spoken with, five informed us there were not enough staff to meet their needs, resulting in them waiting for long periods of time for staff assistance to help them to the toilet. People told us baths and showers were only available if there was enough staff. Staff confirmed at times there were not enough staff to ensure people received timely care and support. We observed people who were looked after in their

bedrooms, including those on end of life care were not getting the same quality of interaction as others. The manager informed us they were in the process of recruiting new staff and would be reviewing staffing levels.

Overall people and their relatives spoke positively of the service, with food scoring highly. Friends and family believed the precautions regarding COVID 19 had been managed well in accordance with government guidelines but were saddened by the impact of visiting restrictions on their family and themselves.

People, their relatives and staff told us in the short time the new manager had been in post, under their direction the culture in the service had improved. Staff felt supported, had better direction and leadership, and had received training that gave them the skills and knowledge they needed to carry out their roles effectively.

Infection control and prevention measures were in place and we were assured the service had systems in place to respond to coronavirus and other infection outbreaks effectively. Staff were clear of safeguarding processes, and when and how to raise concerns.

Why we inspected
We carried out an unannounced focussed inspection of this service on 01 December 2020. This was because the service had not had a registered manager in post since the last inspection in November 2019, which is a breach of the providers conditions of registration. We also received concerns in relation to lack of staff, medicines management and people's care needs not being met. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

Rating at last inspection: The last rating for this service was good (published 12 March 2020) with a rating of requires improvement in the key question well led. At this inspection we found not enough improvement had been made in well led. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement.
Please see the safe and well led sections of this report. You can see what action we have asked the provider to take at the end of this full report.

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

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 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 coronavirus and other infection outbreaks effectively.

Follow up
We will continue to monitor information we receive about the service until we 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 well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

CareQuality Commission

Highfield House 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
This inspection was carried out by two inspectors on 01 December 2020. The inspection was supported by an assistant inspector who spoke with staff by telephone calls on 04 December 2020 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. The Expert by Experience spoke with people and their relatives on 02 December 2020 over the telephone.

Service and service type
Highfield House 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 new manager in post who was not yet registered with the Care Quality Commission. Registered managers and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took 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 nine people who used the service and two relatives about their experience of the care provided. We also spoke with the regional manager, registered manager, deputy manager, two senior care staff, two care staff, the head housekeeper, and two housekeepers. We observed people's care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at 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. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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.

Using medicines safely
• Improvements were needed to ensure people's prescribed medicines, including controlled drugs were stored, administered and disposed of safely in accordance with relevant national best practice guidance.
• Random sampling of people's routine medicines, against their records found people were not always receiving their medicines as prescribed by their GP. Medication Administration Records (MAR) had missing signatures. There was no information recorded to reflect why medicines had not been administered. The running total of medicines had not been completed daily and therefore staff failed to identify where people had not been administered their medicines.
• Where people were prescribed patches to manage symptoms or pain, instructions for applying these were not clearly recorded. For example, a person prescribed patches to manage their Alzheimer's stated apply one patch daily, but not to the same area of skin twice within 14 days. A body chart did not include this instruction; therefore, staff were not applying the patches as directed.
• There were no clear protocols in place to guide staff when medicines prescribed on an 'as required' (PRN) should be administered. This did not ensure people had access to medicines such as pain relief, when they needed it.
• Topical medicines (creams and ointments) charts were not being completed to reflect these were being applied, as directed by the GP. Charts lacked information for staff as to why, when, and where to apply the topical medicines, and any known associated risk. Creams and ointments had been opened and in use without dates recorded of when they were opened and their expiry dates.

People were at risk of harm where their medicines were not being administered accurately, and in accordance with prescriber instructions. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• The previous inspection identified personal risks to people's health and welfare had not always been fully assessed or steps put in place to keep them safe. At this inspection we found further work was needed to ensure risks to people such as, choking, mobility and developing pressure wounds were properly documented, and followed by staff. For example, a person's choking risk assessments, had a written statement on desired outcome, 'to maintain a well-balanced diet' but did not have detailed information on how staff were to mitigate the risk of choking.
• Poor record keeping was placing people at risk of not receiving the care and support they needed. For

example, a person's skin support needs had been assessed as very high risk of developing pressure wounds. They had an existing pressure wound on their right foot. Their handling assessment stated they needed repositioning two hourly day and night. Their records were disorganised and had gaps in recording which meant staff were unable to demonstrate the person had been repositioned, as instructed and increased the risk of developing further pressure wounds.
• Fire systems and equipment were checked regularly, and routine fire drills carried out to ensure staff knew what to do in an emergency. However, we found gates at the top and bottom of stairs had been fitted with locks to prevent people accessing these unescorted. The locks required a key to unlock the gates. Both sets of stairs were identified as fire escape routes and would have taken critical time in event of fire to unlock. This had not been factored into the fire safety risk assessment. The area manager took immediate action assess the risk and ordered keypad locks which will automatically release in the event of a fire.

Staffing and recruitment
• People using the service were mixed in their opinion about staffing levels. Five out of the nine people spoken with told us there were staff shortages which meant they often waited a long time for assistance to go to the toilet and baths or showers were only available if there was enough staff. One person told us, "They're really too busy. It's when I ring the bell. Wait time varies". Another person commented, "No, not always enough staff, there is a general shortage. Call bells not always answered quickly".
• Staff told us at times there were not enough staff to ensure people received timely care and support. Comments included, "Sometimes we don't have enough staff to get things done, such as helping people when buzzers go off, and toileting doesn't get done in good time," and "If we do have day's where we are short staffed, it can be quite stressful."
• The manager had completed an assessment setting out current staffing levels according to the needs of the people using the service. Following the inspection and feedback about staffing the manager told us they were reviewing staffing numbers and recruiting new staff.
• Agency staff were used to support sickness during the COVID 19 pandemic and block booked to the service as part of the providers winter plan to staff the service in the event of a further outbreak of Coronavirus. The agency was booked solely for Highfield House to prevent them moving across other services with the risk of spreading infection. As they were regular to the service, they had good knowledge of people and processes in the service.
• Staff told us they had received an induction when they started working at the service, however they said the process could have been better. One staff member commented, "The general consensus was if you have previously worked in a care setting, you don't need any form of induction, but I would have liked to have shadowed an experienced member of staff at first to get to know the service, the people and other staff. I don't think you should just be told what to do, you should have it explained and be shown and reasons why we do things."

Preventing and controlling infection
• The provider had systems in place preventing visitors from catching and spreading infections.
• Peoples friends and family believed the precautions in place regarding visiting were in line with government COVID 19 guidelines. One relative told us, "I think they've (staff) done really well, they have a booth which is accessed via the garden, so we don't have contact with other residents or go through the home. We have our temperature taken, wear masks and there is hand sanitiser available at the door."
• We were assured the provider was meeting shielding and social distancing rules. Staff were allocated to either the ground or first floor, so they supported the same people minimising the risk of spreading infection. One member of staff commented, "We have our own little bubbles within the home, and we tend to stay within those bubbles."
• We were assured the provider was admitting people safely to the service. The manager confirmed no new people had been admitted to the home in recent months. Where people had returned from hospital, a

negative COVID 19 test was needed before being readmitted back to the service and then a period of self-isolation, as per government guidance.
• We were assured the provider was using Personal Protective Equipment (PPE) effectively and safely. Staff had access to plenty of PPE and had been trained on how to use it.
• We were assured the provider was accessing testing for people using the service and staff.
• We were somewhat assured the provider was promoting safety through the layout and hygiene practices of the premises. Highfield House is a large care home spread over two floors with a mezzanine. At the time of the inspection we raised concern with the manager if two housekeeping staff were sufficient to keep the home clean, including frequent cleaning of high touch areas, such as light switches and door handles. Housekeeping staff told us two staff was a struggle to get everything done. The manager confirmed they were in the process of reviewing housekeepers' hours and recruiting an additional 16 hours to help with cleaning and laundry.
• The provider had a winter plan in place setting out plans to ensure infection outbreaks could be effectively prevented or managed. Currently the service has no positive cases of COVD 19, however the manager told us they have empty rooms and have identified where they can zone parts of the building to ensure people identified with COVID 19 could be contained in one area of the building with designated staff to prevent the virus spreading.
• We were assured that the provider's infection prevention and control policy was up to date. This had been reviewed in line with changes in government policy to ensure staff were following the most recent guidance.

Learning lessons when things go wrong
• Where things had gone wrong investigations had been undertaken to review what happened, the actions taken and lessons learned, however these do not explore what led to the incidents occurring. Investigations need to be more robust to look at the root cause of why incidents have occurred and used to drive required improvements.

Systems and processes to safeguard people from the risk of abuse
• Staff confirmed they had access to the providers safeguarding policy and procedures and knew how and who to report concerns too.
• Staff had completed safeguarding training and were aware of the different forms of abuse and their responsibilities to report safeguarding concerns promptly. One member of staff commented, "I think I would be able to report anything. I would report to my senior or a manager. I could go higher up if I needed."
• The manager was aware of their responsibility to liaise with the local authority. Where safeguarding concerns had been raised, such incidents had been managed well.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

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

• Our last inspection in November 2019 found management and leadership had been inconsistent. Following the inspection, the registered manager left, a new manager was appointed, but resigned in December 2019 leaving the service without a registered manager. The deputy manager supported by the area manager had been overseeing the day to day management of the service. A new manager started in post in October 2020 and has made an application to the Commission to become the registered manager. The changes in management had led to continued inconsistencies in leadership and effective oversight of the service.

• The previous inspection identified systems to monitor the quality and safety of the service had not been effective. At this inspection we continued to find the quality assurance processes had not been fully embedded and used effectively to identify where improvements were needed. For example, medicines audits and staff competency assessments had not identified the issues we found during this inspection as documented in the safe section of this report.

• The area manager had carried out bi-monthly provider visit reports. They provided the two most recent reports, dated 07 September and 18 December 2020. The later report was completed post inspection and included recording on MAR charts and PRN protocols needed to improve, however there was no robust action plan in place to reflect how these issues were going to be addressed and monitored to ensure the required improvements were made and by when.

• Following the inspection, the area manager and manager told us they had taken immediate action to rectify some of the issues we found relating to fire safety and improved record keeping.

We recommend the provider seek advice and guidance from a reputable source, about implementing a robust governance system that identifies and manages risks to the quality of the service and is used to drive improvement.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, and how the provider understands and acts on duty of candour responsibility.

• The manager told us they were aware of what was needed to improve the service. They had developed a three month action plan setting out their immediate priorities to improve the culture in the service, including staff being accountable for their actions and improving communication amongst the team.

• The manager had a visible presence in the service, completing daily walk arounds, attended regular handover and daily meetings to address any immediate issues with staff directly.
• People, their relatives and staff told us in the short time the manager had been in post they had already made a difference. People's comments included, "The manager comes to see everybody, every day to make sure they're alright," and "The manager we have now is very nice indeed. I can talk with them at any time or about anything. I think they have made changes which have impacted on the quality of the service. Everybody is more friendly. The manager is lovely, they couldn't do any more for you."
• Staff told us, the manager was kind, a good leader and they felt under their leadership there had already been a significant improvement in the service. Comments included, "They have changed a lot already, staff morale has improved, spreading the work across the team has reduced stress on staff, sharing out and having equal responsibilities, it is improving," and "We have a new manager, and everything is evolving and changing."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The manager engaged well with people who used the service, their relatives, staff, health professionals and other stakeholders.
• People's relatives described an open culture whereby they were kept informed about their family member and issues in the service, including visiting during COVID restrictions. They told us any issues they raised were dealt with properly and fairly.
• Staff told us regular meetings were now taking place where they were kept informed about changes and asked for their ideas to improve the service. One member of staff told us, "Meetings are quite regular, and we discuss organisation of the home and what's new. I think things have got better from issues brought up in these meetings, such as improved allocation sheets, which has led to better team work."
• The manager told us, following the inspection they had held a meeting with staff and asked them to come up with ideas on how they could improve record keeping to better demonstrate peoples care needs were being met.

Continuous learning and improving care
• Staff told us they felt supported, received regular supervision and appraisal to support their professional development.
• The provider had recognised the stresses paced on staff during the Coronavirus pandemic and had initiated Wellbeing clinic for staff to access for support.
• The complaints log and pathways reflect complaints were taken seriously, responded too and the outcome of investigations were used to improve the service.
• A monthly analysis of falls was used to good effect to identify themes and trends. Where repeated falls had been identified referrals had been made to the falls team and actions take to reduce the risk of further falls. Analysis shows there had been a reduction in the number of falls over last 12 months.

Working in partnership with others
• The registered manager and deputy worked well with stakeholders, including the Clinical Commissioning Group (CCG) and the local authority quality improvement and safeguarding teams.
• The manager has developed a good relationship with local GP surgery, nurse practitioners, district nurses, local authority quality improvement team and pharmacy.
• The service had and continues to engage well with the home testing scheme for COVID 19 and have had no further outbreaks of the infection, since the initial outbreak in April 2020.

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 People were at risk of harm where their medicines were not being administered accurately, and in accordance with prescriber instructions.