Highfields Limited

Highfields Nursing Home

Inspection report

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Bulwell
Nottingham
Nottinghamshire
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Tel: 01159278847

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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 caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 11 August 2016. Highfields Nursing Home provides accommodation for a maximum of 42 people who require nursing or personal care, diagnostic and screening procedures and treatment of disease, disorder or injury. On the day of our inspection 30 people were using the service and there was a registered manager in place.

A registered manager was present during the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our previous inspection on 19 January 2016, we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the safe management of people's medicines and the management of the home.

During this inspection we checked to see whether improvements had been made. We found some improvements had been made but further improvements were still required.

Some improvements had been made to the way people's medicines were managed and people received them safely. However the records and protocols used to ensure safe administration were not always in place or accurately completed. Assessments of the risks to people's safety were carried out, but more regular reviews were required. Some of the assessments did not reflect the current risks to people's safety.

Where people had been involved in an accident or incident at the home the incident had been recorded and reported to the registered manager and was investigated. There were enough staff to keep people safe. Parts of the environment required reviewing to ensure they were safe for people to use. People were protected from the risk of harm because staff could identify the potential signs of abuse and knew who to report any concerns to.

People were supported by staff who had completed a detailed induction and training programme. However staff did not always receive regular supervision of their work. The principles of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards, had not always been followed when decisions were made about people's care. People spoke positively about the food provided at the home. We observed an organised lunchtime experience for people on the first floor, however people on the ground floor's experience was more disorganised. People had access to external healthcare professionals when they needed to.

People were treated with respect and dignity by staff. People felt staff were kind and caring. People's records contained limited information about their life history; however plans were in place to improve this. People had been involved in initial decisions about their care and support needs. People were encouraged

to lead independent lives. Information for people on how to access independent advice about decisions they made was accessible.

People told us there were limited activities at the home and our observations confirmed this. Staff responded quickly to people when needed. Parts of people's care records were person centred, focusing on people's preferences. People's diverse needs were respected. People felt able to make a complaint and were confident it would be dealt with appropriately. The registered manager's complaints log was unavailable for us to review during the inspection.

There had been some improvement of the registered manager's auditing processes since the last inspection, but further work was required to ensure the issues raised within this report were identified and addressed in a timely manner. The registered manager was aware of their responsibilities to inform the CQC of incidents that could affect people's lives, but they had not notified us when a decision to approve the deprivation of person's liberty had been authorised. People, relatives and the majority of staff spoke highly of the registered manager. People were encouraged to become involved with the development of the service, however some people were not aware how to.

We identified a continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back of this report.

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

The service was not consistently safe.

Some improvements had been made to the way people's medicines were managed and people received them safely. However the records and protocols used to ensure safe administration were not always in place or accurately completed.

Assessment of the risks to people's safety were carried out, but more regular reviews were required. Some of the assessments did not reflect the current risks to people's safety.

There were enough staff to keep people safe. Parts of the environment required reviewing to ensure they were safe for people to use.

People were protected from the risk of harm because staff could identify the potential signs of abuse and knew who to report any concerns to.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who had completed a detailed induction and training programme. However staff did not always receive regular supervision of their work.

The principles of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards, had not always been followed when decisions were made about people's care.

People spoke positively about the food provided at the home. We observed an organised lunchtime experience for people on the first floor, however people on the ground floor's experience was more disorganised.

People had access to external healthcare professionals when they needed to.

Is the service caring?

Good

The service was caring.

People were treated with respect and dignity by staff. People felt staff were kind and caring.

People's records contained limited information about their life history; however plans were in place to improve this.

People were involved in initial decisions about their care and support needs when they came to the home.

People were encouraged to lead independent lives. Information for people on how to access independent advice about decisions they made was accessible.

Is the service responsive?

Requires Improvement

The service was responsive.

People told us there were limited activities at the home and our observations confirmed this.

Staff responded quickly to people when needed. Parts of people's care records were person centred, focusing on people's preferences.

People's diverse needs were respected.

People felt able to make a complaint and were confident it would be dealt with appropriately. The registered manager's complaints log was unavailable for us to review during the inspection.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There had been some improvement of the registered manager's auditing processes since the last inspection.

The registered manager was aware of their responsibilities to inform the CQC of incidents that could affect people's lives, but they had not notified us when a decision to approve the deprivation of a person's liberty had been authorised.

People, relatives and the majority of staff spoke highly of the registered manager.

People were encouraged to become involved with the

development of the service, however some people were not aware how to be involved.

Highfields 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 11 August 2016 and was unannounced.

The inspection team consisted of one inspector, a specialist nursing advisor 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We also contacted local authority commissioners of adult social care services and Healthwatch and asked them for their views of the service provided. We also spoke with a representative of the Nottinghamshire Fire and Rescue Service.

We spoke with seven people who used the service, five relatives, four members of the care staff, the activities coordinator, a nurse, the cook and the registered manager. We also spoke with two healthcare professionals who were visiting the home at the time of the inspection.

We looked at all or parts of the care records and other relevant records of six people who used the service, as well as a range of records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection on 19 January 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to the management of people's medicines. After our inspection the provider forwarded us an action plan which advised how they would make the required improvements in this area.

Previously, we identified issues regarding medicines stock levels, gaps in people's records, inconsistent ordering processes, a lack of protocols for medicines administered when needed and the temperature of the room and fridge the medicines were stored was not always recorded. During our inspection on 11 August 2016 we checked to see whether these improvements had been made. We found there had been some improvement, but further improvement was required.

People did not raise any concerns with us with regards to how their medicines were managed at the home. A person said, "They're very strict about [medicines]. And I have cream done on my legs regularly." Another person said, "They wait with me for tablets." A relative said, "It's [medicine processes] been quite good." Another relative said, "We've had no concerns with [my family member's] medication."

Medicines were stored securely in locked cupboards and trolleys but the refrigerator used to store medicines was not locked. This could increase the risk of people accessing medicines that could cause them harm.

The temperature of the rooms used to store medicines and the refrigerator were recorded daily and on the day of the inspection was within safe and acceptable limits. However, we noted that the temperature of the ground floor room used to store medicines in had been above this limit on consecutive days between 20 and 27 July 2016 and also on some other occasions. The registered manager told us their pharmacist had been contacted to ensure the medicines could continue to be used safely, during the period in July. We saw temporary air conditioning units were in place, but were told a permanent solution to the heating issue had not yet been finalised.

We observed the administration of medicines and saw staff stayed with people until they had taken their medicines. Staff administering medicines on the day of the inspection knew the people well but we noted there were no photographs on approximately half of the medicines administration records (MARs). We observed that many of the people were unable to give their names to the person administering the medicines. This could increase the risk of medicines being administered to the wrong person.

Additionally, people's MARs did not have a record of people's allergies or their preferences for taking their medicines. This could increase the risk of people receiving inappropriate medicines or having to take their medicines in a way they did not want to or was a risk to their safety.

However, we noted no discrepancies in the recording of when people had taken their medicines. Records were completed accurately. Blood sugar levels were monitored in line with guidance for people with

diabetes. When medicines were to be given only on alternate days or weekly this had been highlighted on the MARs to reduce the risk of error. This would indicate that people received their medicines in line with their prescription.

Protocols were not in place for most 'as needed' medicines. These medicines are administered, as and when required, in some cases to reduce sudden pain, or agitation. Failure to include a protocol for their administration could increase the risk of inconsistent or unnecessary administration of these medicines.

The registered manager told us they were aware of these issues as they had recently had a visit from the local Clinical Commissioning Group, who had identified many of these issues. They told us they were confident that people received their medicines safely, but acknowledged the paperwork and processes to do so were not always in place.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

People's care records contained assessments of the risks they could face whilst living at the home. This included people's ability to mobilise independently, ability to eat and drink safely and developing pressure sores. We saw the majority of these had been reviewed monthly to ensure they were still appropriate to the current risks people faced. However, we did note there were examples where risk assessments had not been updated where the risks had changed. For example, we saw a person's nutritional assessment had been completed in March 2016 and despite the person losing significant amounts of weight and a dietician being involved, the assessment had not been updated. We also saw other examples, such as pressure sore risk assessments that had not been updated. Inconsistent reviewing of the risks to people's safety could have an impact on their health and welfare.

Before the inspection, we were informed by the Nottinghamshire Fire and Rescue Service that a fire enforcement notice had been placed on the home. This was because parts of the home did not meet current fire regulations and could place people's safety at risk. We discussed this with the registered manager. They told us these parts of the home had been closed, or temporarily amended, to reduce the risk to people's safety. The home has been given a deadline of October 2016 to make the required permanent amendments and the registered manager told us plans were in place to ensure this deadline was met.

We noted other parts of the home and the equipment used to support were regularly checked by staff and the registered manager to ensure they were safe. However, we did see some cleaning equipment such as vacuum cleaners and other equipment such as hoists stored in corridors. We also noted some rooms, which should have been locked, such as storage rooms, were not. These issues could increase the risk to people's safety.

Staff told us they had sufficient equipment to meet people's needs and we observed staff using moving and handling equipment safely. Pressure relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers and they were functioning correctly. We noted one pressure relieving mattress was set on a setting that was too firm for the person using it. We asked whether regular checks of the mattress settings were carried out and we were told there was no system in place for this.

Regular reviews of accidents and incidents that occurred at the home were carried out. Where trends or themes had been identified, preventative measures were put in place to reduce the risk of reoccurrence. People had personalised emergency evacuation plans in place to assist staff with evacuating them safely in an emergency.

People told us they felt safe living at the home. One person said, "I do feel safer here than in the first place I was in." Another person said, "I have my own den in my room so I feel secure." A relative said, "It's better with the alterations [to the home] going on."

People were supported by staff who understood the types of abuse people could face at the home. They knew the procedure for reporting concerns both internally and to external bodies such as the CQC, the local authority or the police. A staff member told us they felt the registered manager would act on their concerns but they told us they would report concerns externally if necessary. Records showed a safeguarding adults policy was in place and that staff had received safeguarding of adults training, which ensured their knowledge met current best practice guidelines.

We received mixed feedback when we asked people if they felt there were enough staff in place to provide them with the support they needed. Whilst some people felt there were, others did not agree. One person said, "I think there are enough people." Another person said, "No, I don't think there's enough staff on." Relatives also gave mixed responses. One relative said, "There's normally a lot around." However another relative said, "They're often short staffed in the lounge as they run off to answer alarms."

Staff told us they felt there were generally enough staff on duty to provide the care required and some staff referred to the recent additions to staffing levels which they felt were required. They told us that when there were short notice absences, efforts were made to try to cover the absence with other staff and where necessary the other homes, within the provider's group of home, were asked if their staff could assist. In this way, most absences were covered. One member of staff said, "Nine out of ten times there is cover."

We spoke with registered manager and discussed how they ensured people were provided with the appropriate number of staff to keep them safe. They told us regular assessments of people's dependency levels were carried out, and where risks had been identified, extra staff were put in place. We found staff were available for people throughout the day and responded quickly to call bells being pressed. We noted one person had been assigned continuous support, also known as one to one support, and staff were with this person as required.

Safe recruitment procedures were in place. Checks on staff suitability to carry out their role before they commenced work were carried out. This included checks to establish whether a potential member of staff had a criminal record and whether they had sufficient references and proof of identity. This reduced the risk of people receiving care and support from unsuitable staff.

Requires Improvement

Is the service effective?

Our findings

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. We checked whether the service was working within the principles of the MCA.

We viewed people's care records and found the implementation of the MCA to be inconsistent. For example, we saw some examples where for some people we would have expected to see evidence of mental capacity assessments and none were in place, and we saw others where mental capacity assessments had been undertaken but documentation to show how staff had reached a particular decision, known as a best interest decision, were not always documented. For other people, we saw mental capacity assessments and best interest decisions had been recorded for some aspects of their care for day to day decisions about the activities of daily living, but not for more major decisions such as taking their medicines or the use of bed rails. This inconsistent approach to the use of the MCA could increase the risk of decisions being for them that were not in their best interest.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We looked at the documentation for three people for whom the authorising body had agreed to the application to deprive them of their liberty. We found staff were adhering to the terms of the DoLS. At the time of the inspection the registered manager, or other appropriate person had not notified the CQC of these decisions. However, after the inspection they had done so.

Staff had a good understanding of the MCA and DoLS, and were able to explain how they used this when supporting people.

Some people had 'do not attempt cardiopulmonary resuscitation' (DNACPR) documentation in place. These had been completed by the person's GP or other appropriate professional person. This meant that the decision for CPR to not be carried out had been taken, if it may have a detrimental effect on the person's on-going health.

People told us staff asked their consent before supporting them. One person said, "They don't push you to do something." Another person said, "Yes, they do ask me before helping."

People's records contained examples where people had given their written consent to a decision. This included the use of their photographs. We observed staff asking people for their consent before assisting them with going to the toilet and moving for lunch, However, we did not see staff request consent when placing food protectors on people before lunch was served.

The majority of people and relatives we spoke with told us they felt staff understood their needs and had the skills needed to provide them with effective care and support. One person said, "I think they do well." Another person said, "Some are better than others. They just do the basic things for us." A relative said, "They're really good here." Another relative said, "They all seem capable."

Records showed that staff received a wide ranging induction and training programme designed to equip them with the skills needed to support people effectively. Training was carried out in a number of areas such as moving and handling, mental capacity and fire safety. Records showed training for the care staff was up to date although refresher training in moving and handling was required for some staff. After the inspection we were informed this had now been booked.

Staff told us they felt well trained and supported. Although one member of staff felt their induction was a little short and others felt they did not receive regular supervision of their work as often as others. We reviewed the process for completing supervisions. The registered manager told us they had implemented a process where other senior staff members such as nurses, were now responsible for carrying out some supervisions. However, when we checked the records we found there was an inconsistent approach to completing them, with significant gaps for some staff. The registered manager told us they would speak with the staff involved and remind them of the need to complete the supervisions when they were required.

We observed staff support people effectively when they displayed behaviours that may challenge. We observed a staff member support as person who had become upset and was beginning to show signs of aggression. The staff member was calm and reassuring and calmed the person down before they posed a risk to themselves or others.

Some adaptations had been made to the design of the home to support people living with dementia. Some bathrooms and toilets were clearly identified and some bedrooms had people's pictures and names on to aid identification. However, other parts of the home, and in particular the first floor, lacked signage to assist people with orientating themselves around the home. The registered manager told us they would review the signage in the home and make improvements where required.

People told us they liked the food provided for them. One person said, "Some things I'm not keen on, but they don't nag me to finish. We get well fed." Another person said, "I couldn't complain and we get plenty of it. I'm sure they'd do something different if I asked." Another person said, "I love eating regularly and eat as much as I can. Fish and chips on Friday is my favourite, and Sunday roast." A relative said, "I'd eat it myself, it looks nice."

We observed the lunch time experience in the two dining areas. In the upstairs dining area people received their meals in a timely manner and were supported with eating their meals. However, in the downstairs dining area the lunchtime experience for people appeared to be unstructured. Some people received their meals in a timely manner and appeared to enjoy them. However, we heard others complaining that part of the meal was undercooked. We also noted that one person had not received their meal, whilst others around them had. The person had to remind staff. Some people received support from staff, however others who also needed support, received little or no engagement from staff.

People's care records contained care plans for eating and drinking. We also saw a person received enteral nutrition. This is where a person receives their normal oral diet, liquid supplements or delivery of part or all of the daily requirements by use of a tube. The person's care records had a clear regime and there had been regular reviews by the nutrition service. There was also a clear record of the administration of the nutrition by staff.

Where people's health was at risk due to excessive weight loss or gain, plans were in place to monitor and record the amounts people consumed. Where needed, referrals to external healthcare professionals such as dieticians were made to obtain guidance for staff on how to support people effectively with their food and drink intake.

People told us they had access to external healthcare professionals such as GPs and dentists when they wanted to. One person said, "I've seen the optician and chiropodist here. There's a carer who comes in at weekends to do our hair and another does my nails." Another person said, "I see the chiropodist every six weeks and the girl here trims my hair. I've been for eye drops at the hospital." Although one person said, "The dentist and optician haven't been here for quite a while." A relative said, "They've been good getting the doctor to [my family member]. The chiropodist comes to them and they get their hair and nails done in here."

Care records contained good evidence of the involvement of a range of professionals in people's care. For example, some people were regularly seen by members of the dementia outreach team, others had seen a dietician, the falls service, continence advisor, podiatrist and speech and language therapist. We were told by the registered manager that a GP visited the home weekly but staff called the GP practice for a visit in between if they needed it.

We spoke with two healthcare professionals who visited the home during the inspection. They both told us they thought staff acted on their advice and that the people they saw each time they visited were well cared for.

Good

Is the service caring?

Our findings

People told us they felt the staff were kind and caring and they enjoyed living at the home. One person said, "They treat me very well." Another person said, "To me, they're very good." Another person said, "They're all nice and sweet to us."

Relative spoken with agreed. "Yes, they are caring. I feel at home when I'm here." Another relative said, "They're lovely staff." Another relative said, "[My family member's] face lights up when they recognise some of the staff. They're all lovely to [my family member]."

People's care records contained some information about their life history and personal preferences. The staff we spoke with had a good understanding of people's needs and could explain what was important to them. The majority of people we spoke with told us they felt staff understood what was important to them.

We observed some positive interactions between people and staff. Staff were kind and caring and we saw some staff with very good interpersonal skills, explaining things to people and taking time to understand their wishes. We observed a person being moved using a hoist. Staff talked the person through the process and gave them lots of reassurance throughout the process.

Staff responded quickly to people who showed signs of distress or discomfort and offered reassurance where needed.

We observed staff giving people choices about the day to day decisions in their life. This included where they would like to sit, what drinks they would like and when they wanted to return to their bedroom. We observed people responded well to this. However, we saw limited examples within people's care records to show that they were involved in more detailed decisions about their care. The staff we spoke with assured us people were involved.

Information was available for people about how they could access and receive support from an independent advocate to make major decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care.

People told us staff protected and respected their right to be treated with dignity and to respect their private space. One person said, "They're very good at knocking and letting me be private in the toilet." Another person said, "I like it when they're polite. They keep things private for me too."

We noted there was limited space, other than people's own bedrooms, where people could have some quiet, private time to themselves. The registered manager told us this was mainly due to the fire enforcement notice in place at the home, but they were confident that when the renovations were completed, more private space would be available.

We observed staff support and respect people's right to privacy. Staff were able to discuss the steps they took to protect people's privacy and dignity on a day to day basis. They mentioned knocking on bedroom doors before entering, closing the door and curtains and covering people as much as possible during personal care. We also saw people's records were stored safely, and treated respectfully, protecting people's right to privacy.

We observed most staff treated people with dignity and respect throughout the inspection. When they entered a room they acknowledged the people in the room by saying hello and asking them how they were. Where people were moved using a hoist they ensured the person's dignity was maintained. However we did note one occasion when a person's bedroom door was left open when they were moving the person using the hoist.

People told us staff encouraged them to be independent and to do as much for themselves as they would like to do. One person said, "I try to carry on as much as I can." Another person said, "It's great to be independent. I'm lucky." Another person said, "I do what I can."

We observed people being encouraged by staff to lead independent lives. This included enabling people to move around the home on their own, but staff were there to support if they needed it. Staff offered continuous encouragement and reassurance.

People and relatives told us, and the registered manager confirmed that there were no restrictions on friends or family coming to visit. One person said, "They can come anytime." A relative said, "I join [my family member] most days for lunch." Another relative said, "It's good that we can come at any time."

Requires Improvement

Is the service responsive?

Our findings

Most of the people and relatives we spoke with raised concerns with regards to the lack of activities provided at the home. One person said, "There's not a lot really. Sometimes a quiz. A lady does it but she's a bit too loud and bouncy for me. I've made a friend here and we have a cuppa and chat together in the evening." Another person said, "They've [the provider] got mean with money. Nothing goes on now, just once in a while with each of us. I've never heard of any outings." Another person said, "No, there's nothing on. I don't go anywhere, I just read my books."

A relative said, "I haven't seen anything much, someone spent some time with [my family member] looking at animal pictures." Another relative said, "More interaction would be good. I've never seen a list of what they do. [My family member] made an Easter bonnet once." However one relative praised the staff and said, "They let [my family member] wash up a plate, dry up, set the table and help out. They'll do a painting too."

We asked staff about the activities provided at the home. They told us there were some activities for people and they tried to find things to engage people. They mentioned bingo, painting and colouring, newspapers and books, and sing songs. They told us they had external entertainers approximately once a month such as a motivator who was good at engaging with people and encouraging them to join activities. However, staff mentioned that some people were left out because they could not participate.

The two external healthcare professionals we spoke with during the inspection both said they thought activities at the home were minimal. However, one of the professionals did praise the staff who supported a person with continuous supervision. They told us the staff engaged the person using an iPad bought for them by their family, along with reading newspapers and listening to music with them. They told us they had seen a significant improvement in this person's mood as a result of the staff interaction.

We observed some staff make attempts to interact with people and to talk to them about the things that interested them. However, they were hampered by the current layout of the ground floor. As a result of the fire enforcement notice, parts of the home, formerly used for activities and social gatherings were now out of use. This meant more people were crowded into smaller spaces. We noted in the afternoon of the inspection, this area was very busy, with very limited space for any activities or meaningful conversation. We also noted one person had been sat at a table with little engagement for a number of hours.

We spoke with the activities coordinator who told us they tried their best to engage people in activities but there were occasions when they were asked to support the staffing team with care duties. They told us this could impact on the time they had to support people with their interests.

We raised these concerns with the registered manager. They told us their activities coordinator tried to engage people as much as possible, but the current layout of the home made this difficult. They told us they would review how best to incorporate people's hobbies and interests into the space they have at the home. We saw no list of activities in the home to inform people of what was on offer to them.

We saw limited examples within people's care records that showed they had been involved with planning their care. The majority of the people we spoke with told us they had not been involved following initial discussions when they came to the home. One person said, "I've not really been involved." Another person said, "No, they don't involve me." Another person said, "They come and tell me if anything is changing."

However, people's relatives told us they had been involved in decisions about their family member's care. One relative said, "They keep me in touch. I'm in every day anyway so see them quite often." Another relative said, "What I like is that the slightest thing, they let me know."

Most care plans contained personalised information about the person and their needs and preferences. For example, their preference for female staff to assist with their personal hygiene. We also noted some records had a life story questionnaire completed.

Most people had a range of care plans in place to provide information for staff about their care and support needs. These had generally been updated monthly and when changes had occurred this had been documented. However, we did find examples where these reviews stated that there had been no changes, when in fact there had. For example, we found a person's nutritional care plan stated no change, when other records showed they had lost 10kg in weight. This meant some people's care planning documentation may not reflect their current care needs.

Care records contained information regarding people's diverse needs and provided support for how staff could meet those needs. One person told us a priest visited them regularly.

People were provided with a complaints policy within their service user guide when they came to the home. We also a complaints procedure in the reception area of the home. The procedure contained guidance on how people could complain to external agencies if they wished to. However, the format the procedure was written in may not be accessible for some people living with communication needs.

People told us they felt able to make a complaint if they needed to. People were confident they could speak to staff about any concern or complaint they may have and felt it would be acted on. However, one person told us they felt nothing had happened when they did complain.

We asked to see the registered manager's complaints register however they were unable to provide this. Therefore we were unable to assess whether people's complaints had been managed and responded to appropriately and in line with company policy.

Requires Improvement

Is the service well-led?

Our findings

During our previous inspection on 19 January 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to registered manager's auditing processes operating effectively. They had failed to identify the issues with people's medicines along with areas such as a lack of staff supervision, the failure to submit statutory notifications relating to potential safeguarding incidents and when people had passed away, and the inconsistencies with people's personal emergency evacuation plans. After the inspection the provider sent us an action plan which explained how they planned to make the required improvements.

During our inspection on 11 August 2016 we found some improvements had been made and the regulation had been complied with, but further improvement was required.

The registered manager showed us their new auditing processes which were completed daily, weekly, monthly and annually. These audits focused on key areas of the home, including medicines, staff performance, people's care records and the environment in which people lived. We saw these audits had been completed. However, they had not always identified the issues that were still in place from the previous inspection.

There had been improvement in people's evacuation plans and an improvement in the number of notifications sent to the CQC, but the audits had not addressed the main area of concern regarding people's medicines. We saw one audit had identified some of the issues we found regarding people's medicines, but there was no robust plan of action in place that addressed these issues.

It was clear from this inspection the registered manager required support in their role to manage the home effectively. Highfield Nursing Home is a very busy home, with a high proportion of people living with complex health needs. There was no deputy manager in place which meant the registered manager had, at times, too much to do. Ineffective delegation of tasks to other senior staff such as nurses meant too much responsibility for the effective, day to day management of the home, remained with the registered manager. We discussed this with them. They told us the provider had plans in place to employ a deputy manager over the coming months. They told us this appointment would enable the managerial tasks to be shared, freeing up the registered manager.

The majority of people and relatives spoke highly of the registered manager. One person said, "I think the home is well run. I know her, she's alright." Another person said, "I think management are ok but staff numbers need looking at." A relative said, "She's very approachable. I've dealt with her quite a bit regarding [a personal matter] recently." Another relative said, "She is very approachable."

The manager was a visible presence throughout the inspection. They interacted well with people and they responded well to her. The majority of staff spoke highly of the registered manager. Most staff told us they found her approachable and they had a good relationship with her. However, some staff said this could vary from day to day.

People and relatives were provided with a variety of formats where they were able to contribute to the development of the service. Questionnaires had been sent and meetings were in place for people to raise any issues they may have. However the people and relatives we spoke with were not aware of a questionnaire being sent or meetings taking place.

Staff told us they would be comfortable raising issues using the processes set out in the whistleblowing policy. They felt that management would take action if any serious concerns were raised with them.

Most people liked the atmosphere within the home. A relative said, "It's friendly." Another relative said, "It's a welcoming place". However, one person who lived at the home said, "It's a bit noisy for me. I like peace." The ground floor of the home did appear very busy and loud at times. This was mainly due to the temporary changes to the layout of the ground floor which had impacted on the number of people sat together in the same place. There was a much calmer atmosphere on the first floor.

The registered manager told us they were aware of their responsibilities to meet the conditions of their CQC registration. The CQC must be informed via a statutory notification if a person receives a serious injury or if they were being deprived of their liberty. We noted a significant improvement in the number of notifications that had been sent to us. However, we did note that authorised DoLS applications had not been notified to the CQC. After the inspection these were then sent to the CQC.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure the proper and safe management of medicines.