Care Quality Commission

Accommodating Care (Newent) Limited

Highfield Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on the 27 February and 2 March 2015 and was unannounced. At the last inspection on 27 August 2014 there were two breaches in regulation which related to management of medicines and monitoring the quality of the service.

The provider sent us an action plan which showed improvements would be made by September 2014. At this inspection we found there was still a breach of regulation relating to management of medicines. The breach of regulation relating to quality assurance had been met.

Highfield Residential Home is a care home for up to 27 older people. At the time of our inspection there were 23 people living in the home.

The home had a registered manager. 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.

Summary of findings

Some aspects of the management of people's medicines were unsafe. People were not protected against being cared for by unsuitable staff because robust recruitment procedures were not always applied.

We had not been notified of some incidents affecting the wellbeing of people living at the home. CQC monitors events affecting the welfare, health and safety of people living in the home through notifications that providers are required to send to us.

The Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS) had not been used correctly to uphold people's rights.

People were protected from the risk of abuse by staff who understood safeguarding procedures. There were sufficient staff to meet people's needs.

People received support from caring staff who respected their privacy, dignity and the importance of independence. There were arrangements in place for people and their representatives to raise concerns about the service.

The manager was accessible and open to communication with people using the service and their representatives. Quality assurance checks on the service including the views of people using the service and stakeholders had been completed as a way of ensuring the quality of the service provided.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.This inspection took place at a time where the 2010 regulations were in force. This report refers to evidence found prior to 1 April when the 2010 regulations were in force but reported on after 1 April when the 2014 regulations came into force. You can see what action we told the provider to take at the back of the full version of the report.

We have made a recommendation about adapting the environment for the needs of people with dementia.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not fully safe.

The management of medicines was unsafe and did not protect people using the service.

Although there were sufficient numbers of staff, people were not protected from the appointment of unsuitable staff because robust recruitment practices were not always operated.

People were protected from abuse because staff understood how to protect them.

Is the service effective?

Requires Improvement 

The service was not fully effective.

People's rights were not protected because the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards were not understood and had not been used correctly.

People were cared for by staff who received appropriate training and support to carry out their roles.

People were consulted about meal preferences and supported to eat a balanced diet.

People were supported through access and liaison with health care professionals.

Is the service caring?

Good 

The service was caring.

People received care from staff who showed concern for their wellbeing and acted to ensure their comfort.

People and their representatives were consulted about the care provided to meet their needs.

People's privacy, dignity and their independence was promoted and respected by staff.

Is the service responsive?

Good 

The service was responsive.

People received individualised care were supported to take part in a choice of activities.

There were arrangements to respond to any concerns and complaints by people using the service or their representatives.

Summary of findings

Is the service well-led?

The service was not as well-led as it should be.

Required information in the form of notifications about allegations of abuse affecting people using the service had not been sent to the CQC.

The manager lacked an awareness of key areas in legislation affecting people's rights

Quality assurance systems based on people's views were in place to monitor the quality of care and safety of the home.

The manager was accessible and open to communication with people using the service and their representatives.

There were various meetings in place to encourage open communication with people.

Requires Improvement

Highfield Residential 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 27 February and 2 March 2015 and was unannounced. Our inspection was carried out by one inspector. We spoke with three people who lived in the home and one visitor. We also spoke with the registered manager, the administrator, the cook, the activities organiser and two members of care staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We carried out a tour of the premises, and reviewed records for three people who lived in the home. We looked at four staff recruitment files and information relating to the running and management of the service.

Before the inspection we looked at notifications the service sent to us. Services tell us about important events relating to the service they provide using a notification. We were not able to gather detailed information from the service prior to our inspection because the inspection was brought forward in response to information we had received.

Inadequate

Is the service safe?

Our findings

At out inspection of August 2014 we found a breach in the regulation relating to the management of medicines. This included handwritten entries on the Medication Administration Records (MAR) not being signed by two staff to indicate the information was correct. There were also gaps on the MAR where staff should have signed to indicate if medicines had been given or not. Following our inspection the registered manager sent us an action plan detailing the improvements they would make. During this inspection we found some issues with how people's medicines were managed at Highfield Residential Home. People were still not protected against the risks associated with the unsafe management of their medicines.

People's medicines were stored securely and storage temperatures for the majority of medicines were monitored and recorded. Records of storage temperatures showed that medicines had been stored within the temperature limits. However the temperature of medicines stored in one cupboard were not being monitored therefore it was not clear if these medicines had been stored at the correct temperature. This cupboard was adjacent to a radiator which was giving out heat during our inspection visit. If medicines are not stored properly they may not work in the way they were intended and so pose a potential risk to the health and wellbeing of the person receiving the medicine.

One person using the service told us they received their medicines twice a day and they were given at the right time. Another person told us they received their medicines "every day at the right time". Individual protocols were in place for medicines prescribed to be given as necessary, for example, for aches and pains. There were appropriate records of medicines received into the care home and of medicines returned to the pharmacy. However we found some issues with the recording of medicines given to people. We checked some MAR charts. Some charts had been handwritten for people who had recently moved in to the home at the weekend. There was no signature of the staff who entered the directions for when medicines should be given on the administration chart. There was no evidence that the directions had been checked as correct by another member of staff. For example, one person had moved into the home from hospital with a specific medicine to be given on a regular basis and as an 'as required' dose. The 'as required' dose had not been entered on the MAR. Checking by a second member of staff would have reduced the risk of this error occurring.

We also found that there were gaps in the recording of when people had taken their medicines. There were no signatures or codes recorded on the MAR for when medicines were taken or not taken for some people for 28 February and the 1 March 2015.

The 'Administration of Medication Policy' in use and reviewed in October 2014 did not reflect the practices for looking after and giving people their medicines at Highfield Residential Home. For example the policy referred to a domiciliary care agency and to practices that may have been found when care is provided to people in their own homes.

We found that the registered person had not protected people against the unsafe use and management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were placed at risk of being cared for by unsuitable staff because robust recruitment procedures were not always applied. Out of three staff recruitment files we looked at one staff member had been employed without checks of their conduct during all of their previous employment. Their reasons for leaving previous employment which involved caring for vulnerable adults had also not been checked. The care home's recruitment and selection policy did not reflect current regulations relating to employment checks for staff working with vulnerable adults despite a review date of 28 October 2014.

We found that the registered person was not operating effective recruitment procedures because they did not ensure all the information specified in Schedule 3 was available. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Disclosure and barring service (DBS) checks had been carried out. DBS checks are a way that a provider can make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

People were protected from abuse by staff with the knowledge and understanding of safeguarding policies and procedures. Information given to us at the inspection showed all staff had received training in safeguarding adults. Staff were able to describe the arrangements for reporting any allegations of abuse relating to people using the service. People said they felt safe living at Highfield Residential Home. However an allegation of abuse in September 2014 relating to a person falling out of bed had not been reported to the local authority. Information about the incident was reported to the local authority by the hospital where the person received treatment. Following this the service took appropriate action to investigate the incident and took steps to prevent a repeat of the incident.

People had individual risk assessments in place. For example there were risk assessments for pressure area care, falls and the use of bed safety rails. These identified the potential risks to each person and described the measures in place to manage and minimise these risks. Risk assessments had been reviewed on a regular basis. People were protected from financial abuse because there were appropriate systems in place to help support people manage their money safely.

The safety of the home was maintained through actions taken as a result of relevant risk assessments. This helped to ensure that people were protected from risks associated with portable electrical appliances, legionella and fire. Work on the electrical installation was due following a recent inspection by an electrician. Personal fire evacuation plans were in place for people using the service should they need to leave the building in an emergency.

The cleanliness of the premises had been maintained and a recent inspection of food hygiene by the local authority in February 2015 had resulted in the highest score possible.

People at the home told us they felt there were enough staff to meet their needs. One relative who often visited at lunch time told us they felt there was “enough staff” for people’s needs. The registered manager explained how the staffing was arranged to meet the needs of people using the service. For example recently extra staff had been added to support the existing staff team. An extra staff member had been added from 4pm to 9pm since November 2014 as well as the addition of a laundry worker to ease the workload of the care staff. This new arrangement arose, in part, from a response to the issues raised at a staff meeting in August 2014 with the intention of allowing care staff more time for personal care. Staff had mixed views about the current levels of staffing one commented “ok if fully staffed” but others felt more staff were needed at certain times of day. During our inspection we observed that staff responded to people’s needs in a timely manner.

Requires Improvement

Is the service effective?

Our findings

People's rights were not protected by the correct use of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make certain specific decisions for themselves. The DoLS protect people in care homes from inappropriate or unnecessary restrictions on their freedom. Peoples care plans included an assessment of their mental capacity however the assessments were general in nature and did not relate to a specific decision. One assessment stated "does not have the capacity for major decision making, the family act in her best interests".

At the time of our inspection visit there had been no assessments of people relating to restrictions on their liberty. For example, one person had recently moved into the home for a short stay, we discussed their needs with the registered manager who acknowledged that the person may try to leave the care home and staff would have to prevent them. No application had been made for authorisation to deprive this person of their liberty. However on the first day of our inspection the registered manager attended a training session provided by the local authority on DoLS and intended to review all residents with regard to any deprivation of liberty. Six out of 16 staff had received training in the MCA. Some staff we spoke with did not demonstrate knowledge of the MCA and DoLS.

We found that decisions about care and treatment were not always being taken in people's best interests. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service were supported by staff who had received training for their role. People told us that staff knew what they were doing when giving care. People made positive comments about staff such as "all very good" and "pretty good". Staff had received training in such areas as infection control, nutrition and food safety, first aid and moving and handling. We saw training certificates in individual staff files. They told us they felt the training provided by the service was adequate for their role. On the first day of our visit staff were attending a dementia training session provided by a care home support organisation.

Staff had regular individual meetings called supervision sessions with the manager every two months. The registered manager told us they had just started the process of annual staff appraisals. One member of staff told us they had recently had one of these meetings and they received enough support from the manager.

People were regularly consulted about their meal preferences. Minutes of the monthly service user meeting showed how people were asked for their opinions on menus and their views noted One person commented on the "Lovely dinner" which was served "red hot and the pudding was very nice". Another person described the meals as "alright" and described how a choice was available if wanted. One person preferred a diet free of meat. This was recorded clearly on a needs assessment so staff were aware of this. We discussed the meals provided to this person with the manager and the cook. The person was provided with suitable meat free alternatives with appropriate records kept. A four week menu was in use that included a cooked snack at tea time. Copies of the menu were on display for people and their representatives to view.

People's healthcare needs were met through regular healthcare appointments and liaison with health care professionals. One person told us they had been visited by the chiropodist and by their GP. There were appropriate records of healthcare appointments attended by people. As we toured the premises with the registered manager one person raised a concern about their health. This information was quickly relayed to a senior member of staff for a GP visit to be arranged. Staff told us how they would support people to attend health care appointments.

People had been consulted through residents meetings about plans for developing a suitable space outside for people to use. At the time of our inspection there was no suitable outside space for people to use. The registered manager described plans for an area at the rear or the premises which would be developed for people's use. Some work had started on adapting the environment for people with dementia. There had been a recent increase in people with dementia using the service. Individual name cards with pictures had been used for some people's room doors and toilet doors, some painting of corridor walls had started. However the home lacked an overall plan to adapt the environment for the needs of people with dementia.

Requires Improvement

Is the service effective?

It is recommended that the service consider current guidance on adapting the environment for the needs of people with dementia.

Good

Is the service caring?

Our findings

People told us staff treated them with kindness. People using the service made positive comments about the caring nature of the staff, such as "very caring", "caring and polite" and "they treat us the way they would like to be treated themselves". A visitor described the caring nature of the staff as "very good" and commented positively about how staff had worked to improve the personal care of their relative.

Staff were attentive to peoples' needs and regularly checked on their well-being in a friendly but not over familiar manner. For example they showed concern about the comfort of one person, interacting with them until they understood the situation. Staff intervened and checked with the person a number of times until they were satisfied that they were more comfortable. Important information about the person's wellbeing was relayed to a senior member of staff for further consideration. Staff responded to requests for drinks and encouraged one person to drink for their well-being.

People and their representatives had been consulted about plans for their care. We saw examples of people signing their care plans to indicate they were aware of the content of the plans. Minutes of resident's meetings showed how people using the service were given the opportunity to express their views about the service provided. Meetings were held on a monthly basis and the minutes from January 2015 showed how people who did not attend the meeting preferring to remain in their rooms were asked for their views. People were consulted about their views on staff, menus, housekeeping and activities.

There was information available about appropriate local advocacy services. Although we found no evidence that these had been used by people the registered manager was aware of situations where it may be appropriate to use advocates such as where people had no relatives.

People's privacy and dignity was respected. When asked if staff respected their privacy of their room one person told us "they all (the staff) knock your door". Another person also confirmed this and we observed staff doing this during our inspection. Staff gave us examples of how they would respect people's privacy and dignity when providing care and support such as ensuring doors were closed and people were adequately covered when providing personal care. Minutes of a staff meeting from January 2015 demonstrated how the registered manager had reminded staff about the importance of maintaining people's privacy and dignity when giving personal care. One person's care plan included actions for staff to follow to preserve the privacy and dignity of the person when they were receiving personal care. People's preferred names were also recorded for staff to address them correctly.

The registered manager told us how she would discreetly listen to interactions between staff and people to check they were being treated respectfully and had no concerns about the way staff interacted. Staff recognised the importance of promoting independence and gave us examples of how they would enable this when giving care such as encouraging people to carry out some personal care tasks for themselves and encouraging independent mobility. One staff member told us "I do try and make sure they do what they can". One person told us that the staff "ask permission before they do things".

People were able to receive visitors without unnecessary restriction. A visitor told us they were free to "turn up at odd times" to see their relative in the care home.

Good

Is the service responsive?

Our findings

People received personalised care and support. We saw how the service had responded to meet the individual needs of people and listened to their views and wishes. For example, the service had recognised the importance of the companionship of a pet cat for one person. Arrangements had been made for the cat to live in the person's room cared for by them with support from staff. Another person had issues around the provision of cooked meals. To manage this a microwave oven had been installed in their room where snacks could be warmed up for them by staff when needed.

Care plans were personalised with specific and individualised information about people's care needs and the actions for staff to take to meet them. For example the registered manager was aware of the religious needs of one person using the service and described how regular visits had been arranged from a representative of the person's faith. A vicar from a local church also visited residents in the home on a monthly basis to provide holy communion. Where appropriate people or their representatives had been involved in developing and reviewing their care plans.

People were supported to take part in activities. One person told us how much they enjoyed the bingo sessions at the home. A range of activities were held in the home including bingo, sing-a-longs, quizzes, musical movements and visits from a singer. During the second day of our inspection, people were enjoying a film afternoon actively promoted by staff in the front lounge. This was a regular weekly event. Some people arranged their own trips out of the home with family members. Staff demonstrated an awareness of the need to ensure people were offered an opportunity to engage and take part in activities. During our SOFI observation we noted staff speaking to people to check if they wanted to occupy themselves with activities such as board games. One person asked for a newspaper and one was found for them to read.

People's concerns were listened to and addressed by staff. There were arrangements to listen to and respond to any concerns or complaints. Complaints were recorded, investigated and responses provided to complainants. We looked at two complaints received from representatives of people using the service, appropriate responses had been given. People we spoke with were not clear about the exact arrangements for raising a complaint or concern. However they were comfortable to approach the manager or staff with one person saying "I'd have to ask them" and another saying "I'd have to get in touch with the boss". One person told us "I've not one complaint about the place".

Requires Improvement

Is the service well-led?

Our findings

Important events affecting people using the service had not been notified to us, this is a legal requirement. We had not been notified of two allegations of abuse; one in September 2014 and the other in November 2014 both were allegations of neglect. CQC monitors important events affecting the welfare, health and safety of people living in the home through the notifications sent to us by providers.

The home's 'Safeguarding vulnerable adults policy' reviewed in October 2014 described acts of neglect under the definition of abuse. The policy also stated "inform and discuss with the CQC". The registered manager was not aware that allegations of abuse as well as actual incidents of abuse had to be reported to the Care Quality Commission.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager further demonstrated that she did not fully understand her responsibilities in her role through her limited knowledge of MCA and the new judgement in relation to DoLS. This lack of knowledge could lead to difficulties in supporting her staff appropriately in this area. A lack of awareness of key challenges to the service going forward such as the introduction of the new Care Certificate qualification to replace the existing induction training to National Standards for new staff was also evident.

The registered manager told us their vision for the service was "I want people to enjoy living here". This had been shared with staff. The registered manager was visible and accessible to people using the service, staff and visitors and therefore was aware of events at the care home. During our inspection visit, we observed people freely approaching the manager in their office.

Minutes of staff meetings demonstrated that staff were kept informed about developments in the service. Care staff meetings included information and discussions about handover arrangements, staffing and team work. Developments in the service were also reflected such as requests for staff to join a dementia support programme. As well as meetings with care staff, meetings had also been held with cooks and housekeepers where subjects relevant to their respective roles were discussed.

The service had made moves to establish more links with the local community. On both days of our inspection the home was open for people to view the home and on the first day a representative from a care home support organisation was available to answer any queries about dementia. Two people had visited to view the home and were provided with refreshments.

Staff were aware of whistleblowing procedures and of outside agencies that could be contacted with concerns. Whistleblowing allows staff to raise concerns about their service without having to identify themselves.

The home had a registered manager who had been registered as manager of Highfield Residential Home since August 2014. When we asked them about the management of the home, a person using the service told us "I think it is run alright." Other people thought the home was well managed." Staff told us they had "no problems" with the management of the service. During our visit we saw how the registered manager was available to respond to any requests from people, staff and visitors.

People and their representatives were consulted about the quality of the service being provided. A stake holder survey had been carried out in July and August 2014. Questionnaires had been sent to people using the service and their relatives covering areas such as the home environment, attitude of staff, meals and activities. The results had been analysed and fed back to people who took part in the survey with information about planned and completed improvements such as new flooring, a new menu and enabling people to vote in elections. In addition an overview of the findings had been shared with staff.

At our inspection of August 2014 we found a breach in the regulation relating to monitoring the quality of the service provided this related to a lack of auditing of accidents and incidents. Quality audits had also failed to identify issues with people's medicines. At this inspection we found that monthly incident and accident audits had been introduced. Monthly audits of the management of medicines had been introduced although these were still not effective enough for timely identification of issues as evidenced by our findings during this inspection visit. Falls were recorded in an effort to establish if there was any pattern occurring in case any remedial action was required. There were also monthly audits of money looked after for people and of the condition of people's rooms.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Appropriate arrangements were not in place to protect people against the unsafe use and management of medicines. Regulation 12(g)HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Decisions about care and treatment were not always being taken in people's best interests. Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Need for consent

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person was not operating effective recruitment procedures because they did not ensure all the information specified in Schedule 3 was available. Regulation 19 (2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

The registered person had not notified the Commission of incidents which occurred whilst services were being provided in the carrying on of a regulated activity. This included allegations of abuse relating to people using the service.