Jiva Healthcare Limited

The Highviews

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Highviews is a residential care home providing personal care to up to 6 people in an adapted house in a residential area. The service provides support to people with learning disabilities or autistic spectrum disorder, people with mental health conditions, physical disabilities, sensory impairment, dementia, older people and younger adults. At the time of our inspection there were 6 people using the service.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

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

Right Support:
The service did not have enough appropriate staff to support people's needs and keep them safe. Risks to people were not always assessed and managed to ensure people's safety, including environmental risks and fire safety. People did not always receive the support they needed, including when people were at risk of choking.

People were not always receiving their medicines safely and staff were not all trained and assessed as competent to administer medicines.

The insufficient staffing levels had a negative impact on people's quality of life and meant that people were not always supported to have maximum choice and control of their lives. There were restricted opportunities to go out and pursue activities in the local community. One person told us, "I miss being able to meet up with my friends."

Right Care:
Care plans did not include all the information that staff needed and did not reflect current guidance and best practice to provide a planned approach with a focus on people's quality of life. This meant that staff did not have clear guidance in how to support a person who had mental health needs when they were distressed.

People received kind and compassionate care from staff who knew them well. Staff protected and respected people's privacy and dignity. Staff considered matters of consent and understood the importance of protecting people's rights. People told us they were happy living at The Highviews and they had developed positive relationships with staff. One person said, "All the staff are my favourites."

Right Culture:
There had been a lack of leadership at the service. Systems were not in place to support effective oversight and governance. This meant that risks to people were not always identified and managed and records were not consistent and accurate.

Some staff knew people very well and understood their needs and preferences, but people were not supported to increase their skills or independence or to identify and plan for future goals and aspirations.

Following this inspection we asked the provider for assurances about staffing levels and risks to people's safety.

A new manager had recently been appointed and had already identified most of the concerns that we found at this inspection. They had created a service improvement plan with a timescale for actions and this gave us some assurance that the necessary improvements would be made.

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

Rating at last inspection
This service was registered with us on 2 December 2021 and this is the first inspection. The last rating for the service under the previous provider was good, published on 10 July 2019.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, risk management and care planning. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to staffing, management of risks, administration of medicines, personalised care planning and management oversight at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Highviews

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of 2 inspectors.

Service and service type
The Highviews is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Highviews is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for 9 days and had not yet submitted an application to register.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We received feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people and 2 relatives about their experience of the service. We observed staff interacting with people and supporting them and we spoke with the manager. We spoke with 4 staff by telephone following the inspection. We looked at records relating to people's care and the management of the service. Following the inspection we asked for further information to be sent to us, including, risk assessments, staff records and training information.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- There were not enough suitable staff deployed to meet people's needs.
- The provider did not have a suitable system to assess people's needs and ensure staffing levels were adequate to meet their needs. This meant that risks to people were not always managed and people were put at risk of harm. There was a negative impact on people's quality of life.
- A person had been assessed as being at risk of choking. A speech and language therapy (SaLT) assessment identified that they required staff to be with them when they were eating and drinking. We observed they were left alone whilst they were eating their lunchtime meal because the 2 staff on duty were required to support another person. A staff member was heard asking a person to "Keep an eye on," the person who was at risk of choking. This did not support safe practice or respect the dignity of the person.
- People, their relatives and staff told us there were not enough staff to meet people's needs. One person told us, "I used to be able to do more for myself but I need 2 staff now. It's difficult sometimes I have to wait, as other people need help and I can't stand on my own."
- A staff member told us the staffing levels had remained the same for many years. They said, "We don't have enough staff now, people's needs have changed and we need more staff on duty."
- Staff rotas showed that there were times when only 1 member of staff was on duty including at night. Some people needed 2 staff to support them with moving and this meant there were not enough staff on duty to support them if needed. The provider had failed to ensure that staffing levels and staff skills were reviewed to respond to people's changing needs.
- People's quality of life was impacted by the lack of suitable staff, including for one-to-one support for people to take part in activities and visits, how and when they wanted. We have reported on this further in the responsive domain of this report.
- Some staff were working 48 hour shifts. For example, the rota showed some staff were on duty from 8am on Saturday morning until 8am on Monday morning. The manager said arrangements had recently changed so there were now waking night staff in place. This had reduced the length of time some staff were on duty.
- The provider's systems for recruitment included that staff should have a Disclosure and Barring Service (DBS) check in place. DBS checks provide information including details about convictions or cautions held on the Police National Computer. This information helps employers to make safer recruitment decisions. Not all staff had a DBS check in place. The manager confirmed they would take immediate action to obtain up to date DBS checks for staff.

The failure to ensure there were sufficient suitable staff deployed to meet people's needs was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Following the inspection we asked the provider for assurances that they had assessed staffing levels to ensure people's safety and that these levels were being maintained.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

● Risks to people were not consistently assessed, monitored and managed safely. This put people at an increased risk of avoidable harm.

● People were not consistently supported to manage risks associated with eating and drinking.

● Some people had been assessed as being at risk of choking and SaLT assessments indicated that they needed modified foods. Guidelines for staff were not consistently followed. For example, 1 person needed a soft and moist diet but could also have some toast if it was cut into 1.5cm pieces. During the lunchtime meal this person was provided with a toasted sandwich which was not cut into pieces and did not meet the guidelines for safe food. Staff did not remain with the person while they were eating which further increased risks of choking.

● Some risks had not been identified and assessed. One person had respiratory needs and had been prescribed oxygen therapy. There was no risk assessment or care plan in place to guide staff in how to support the person safely with the use of oxygen. Records did not include monitoring oxygen levels and information about how and when to recognise and escalate any concerns. The use and storage of oxygen tanks is an increased fire hazard, and this had not been identified and included in the fire risk assessment for the service. This put people at an increased risk of harm.

● Other environmental risks were noted during this inspection including use of a damaged electrical socket in a person's bedroom, flooring and carpet debris stored in a bathroom and an electric bulb held in place with tape. We brought these fire safety concerns to the attention of the manager who took immediate action to ensure people's safety.

● Some people had poor mobility and spent much of their day in wheelchairs. Assessments had not been completed to identify any risks of developing pressure areas. Staff told us they supported them to change position regularly but there was no guidance in place and no records to provide assurance that this was happening. Although people did not have pressure sores, there was a risk that these could develop as guidance for staff was not in place.

● Risk assessments were referred to in some records but were not available to staff. The manager explained that risks assessments had been removed from the service whilst they were updated. This meant there was a lack of guidance for staff and the provider could not be assured that all risks were being managed safely.

● Systems for managing medicines were not consistently safe.

● People did not always have access to their prescribed medicines. One person had medicine prescribed for epilepsy but their medicines had run out. This meant they had missed their prescribed dose of medicine. The manager arranged for the prescribed medicine to be collected and to be administered on the day of the inspection so no harm came to the person.

● Some people were prescribed PRN (as and when) medicines. All staff who worked at night had not been trained in administering medicines. This meant that if someone needed a PRN medicine during the night there were no staff on duty who were able to administer this medicine.

● Medicine administration record (MAR) charts were not consistently completed in line with national guidelines. For example, some MAR charts had not been signed and there was no record of whether the person had received their medicine or not. Another person required their medicine to be administered on alternate days but their MAR chart had been signed on consecutive days. It was not clear if this meant the person had received an overdose of medicine or whether this was a recording error.

● A person was prescribed a medical patch to support them with pain relief. There was no guidance for staff in the person's care plan about how often this should be changed or where it should be placed on the person's body. A staff member who knew the person well told us they were the only staff member who changed this patch but if they were not available other staff would not have the guidance they needed.

● There were no systems in place to identify, record, and monitor incidents, accidents and near misses. This meant there was a risk that lessons were not learned when things went wrong.

● Staff told us they would record any incidents in people's daily records but incidents rarely happened. There was no system to provide oversight or to verify that this was the case. This meant the provider could not be assured all incidents were recorded, reviewed and investigated to identify causes and that suitable measures were put in place to prevent a reoccurrence.

The lack of risk assessments, failure to manage risks to people, failure to monitor incidents and failures in systems for managing medicines safely meant that people were at risk of avoidable harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The lack of systems for recording incidents meant that the provider could not be assured that potential safeguarding incidents had been recognised and reported in line with safeguarding procedures.
● Staff knew people well and were confident they would recognise signs of abuse. Not all staff were clear about the provider's safeguarding policy or what action they should take if they suspected abuse, however all staff said they would report concerns to a manager.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were not assured that the provider's infection prevention and control policy was up to date.
● There were no restrictions on visitors at the time of the inspection. This was in line with current guidance.

Requires Improvement

Is the service effective?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not received consistent support and training that was relevant to people's needs.
- Staff had undertaken some training but there was not a consistent approach to ensure staff knowledge and skills were developed in line with current standards and best practice. For example, staff had not received training in how to support people using positive behaviour support techniques. The manager explained that this training was a priority for the staff team and this was reflected within their service improvement plan.
- Not all staff had completed training in safeguarding people, this meant the provider could not be assured that staff understood how to recognise signs of abuse or when and how to report safeguarding incidents.
- Staff had not received training in enduring mental health conditions, this meant they did not have all the skills and knowledge they needed to understand and support people living at The Highviews.
- Staff told us they had not always felt supported. One staff member said, "We used to have regular supervision meetings but that has stopped, I can't remember the last time." Staff told us they did not have time to reflect on practice or plan their own development. The manager had identified the need for regular supervision and support for staff within their service development plan.

The lack of staff support and failure to ensure suitable training that was relevant to people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Care and support plans did not reflect current evidence-based guidance and best practice to provide a planned approach with a focus on people's quality of life.
- Care and support plans set out current needs and identified people's preferences but did not always promote strategies, for example to enhance independence. There was little evidence of planning and consideration of the longer-term aspirations of each person.
- There were not always clear plans to guide staff in how to support people who were experiencing distress or communicating an emotional reaction or a need. For example, there were no clear strategies in place for staff to follow. Care plans identified that staff should offer support to people but did not specify how to do so or what support was appropriate based on the person's individual needs.
- The manager had recognised shortfalls in assessments and care plans and told us how they planned to introduce more outcomes based assessments, focussed on meeting people's preferences and developing their skills to increase their independence and autonomy.

Adapting service, design, decoration to meet people's needs.
● People's individual needs were partially met by the physical environment.
● The provider was in the process of refurbishing the home. Where this had been completed people told us this was an improvement, and they were happy with the standard of decoration.
● People were supported to personalise their rooms and were included in decisions relating to the interior decoration and design of their home.
● Some areas of the home were not yet complete, including the outside space which was not all accessible for people who used wheelchairs. This was described as work in progress.

Supporting people to eat and drink enough to maintain a balanced diet
● People had not been consistently involved in choosing food options, shopping for food and preparing their meals. The manager explained how they were making improvements to ensure people were involved. On the day of the inspection people were having a meeting to discuss creating a menu that included their preferences. People were animated about the options they had chosen and told us how they had enjoyed planning the menu.
● We observed how 1 person was involved in cooking with staff and there were plans for other people to have more opportunities to use the kitchen. The lack of staff on duty was a barrier to supporting people to be involved and to maintain and learn new cooking skills. This was an area of practice that needed to improve.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA .
● Staff understood their responsibility to consider issues of consent in line with MCA. People told us, and we observed, how staff checked with people before supporting them.
● Where people may lack capacity to make a decision staff consulted appropriately so that decisions were made in people's best interests.
● One person told us how they were supported by an advocate to ensure their voice was heard and their rights were upheld.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were referred to health care professionals to support their wellbeing and help them to live healthy lives.
● Health needs were assessed, and records showed that people were supported to attend appointments including for annual health care checks with the GP, specialist professionals, dentist, opticians and an occupational therapist.
● Staff worked well with other services and professionals to prevent readmission or admission to hospital. One person told us, "I was glad to be home after being in hospital. The staff know how to support me."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
- Engagement with decisions were limited by the number of staff on duty. For example, a staff member described how a person liked to go out, but staffing levels did not support this, so they were rarely offered this opportunity and spent time in their room watching television.
- Records showed that a person had previously enjoyed attending the local church. A staff member said that current staffing levels could not support this on a regular basis. This meant that people were not fully enabled to make meaningful decisions about their care and support because staff were not able to accommodate their wishes. This is an area of practice that needs to improve.
- Staff told us they tried to offer choices to people whenever possible. We noted that every day choices were offered to people.
- Staff took the time to understand people's individual communication styles and develop a rapport with them. We observed how a staff member used a calm and gentle approach to encourage a person to express their views. The person responded well to this and added their opinion to the discussion. The staff member was careful to validate their contribution and this resulted in a broad smile from the person.

Respecting and promoting people's privacy, dignity and independence
- People rarely had the opportunity to try new experiences, develop new skills and gain independence.
- A relative told us staffing levels did not support this. They said, "People used to be able to do a lot more, they were always off doing things, going on holiday, hopefully they can sort things out."
- Staff knew when people needed their space and privacy and respected this. A person told us, "They (staff) knock on my door when I am in my room. They don't walk in."
- Staff protected people's privacy and dignity. We observed that staff were mindful about people's dignity. A staff member spoke discreetly to people when they needed support with their personal care needs.

Ensuring people are well treated and supported; respecting equality and diversity
- People had developed positive and enduring relationships with the staff. There was 1 member of permanent staff and a small team of regular care workers from the provider's other home, who had got to know people well. Staff spoke with compassion and pride about people's achievements.
- Staff members showed warmth and respect when interacting with people. People told us they got on well with all the staff at The Highviews. One person told us, "I don't have a favourite because they (staff) are all my favourites." We observed people were relaxed and appeared to enjoy the company of staff, there was lots of laughter and a calm and happy atmosphere.
- People and their relatives were consistently positive about the caring attitude of the staff. One relative told

us, "The staff know people so well, I have no concerns about the care. "Another relative said, "I have absolute confidence in the staff and how they support people."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People were not enabled to make meaningful choices or to have as much control and independence as possible.
- Staff were task focussed and this had a negative impact on people's quality of life. For example, people were allocated specific days to have a shower. Staff said this was because there were not enough staff on duty to support everyone to have a shower when they would like. This meant that people were not encouraged to choose to take a shower when they wanted to.
- Records showed that 1 person was regularly refusing support with personal care and staff were recording that they were completing personal care themselves. However, staff confirmed that the person needed support and would not be able to complete their care needs without staff assistance. The staff member said that they preferred a female member of staff to help them with personal care but there was not always a female staff member available. This meant the person's needs and preferences were not consistently supported.
- People's care and support plans included some personalised details about people's needs and preferences. However, there were shortfalls in how some people's needs were supported. For example, 1 person had an enduring mental health condition. Symptoms of mental ill health were described in terms of inappropriate behaviour or as a bad mood. Guidance for staff included reminding the person that their behaviour was disturbing for other people in the home. This did not support a positive view of the person and did not provide suitable guidance for staff in how to support the person with symptoms of their condition. This brought into question staff understanding of the person's mental health condition.
- Staff who worked at the home regularly knew people very well and this meant they understood people's needs and preferences. One staff member told us, "We have developed strategies over time, we have learned how to deal with things and how to support people." There was a reliance on use of agency staff who were less familiar with people. Care records did not always reflect the details of people's support. This meant that not all staff had the information they needed to provide personalised care.
- Support plans did not focus on people's quality of life outcomes and the provider's systems did not provide a planned approach to supporting people's needs and aspirations. The manager described plans to introduce a more person-centred tool and approach.

The failure to provide a personalised service that was responsive to people's needs and preferences was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were not leading full and active lives because staffing levels at the home did not support this.
● People told us they spent their time doing a puzzle, watching TV or sometimes playing a game. Records showed that people's days were repetitious and varied little. There was little opportunity for people to go out and take part in activities within the local community. One person told us, they sometimes went out alone but most people needed support from staff.
● One person told us their needs had changed and this meant they were no longer able to see their friends regularly. They said, "I am really missing them, but I need staff to go with me now, so I have to wait for them to organise something."
● Records confirmed that people had few opportunities to go out. In the 5 weeks before the inspection people had been out a couple of times only. Two people had only been out once in that time. Staff confirmed this was because there were not enough staff on duty to support people out in the community.

The failure to ensure people's social needs were met was a further breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
● Relatives said staff supported people to stay in touch with them and described communication as good.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● Communication care plans identified people's needs and guided staff in how best to support them, including using visual tools or aids. One person had hearing difficulties and needed to use hearing aids. This was not identified in their communication plan. This meant that staff who were unfamiliar with the person might not have all the information they needed to support them.
● The provider did not have systems in place to fully comply with the Accessible Information Standard. This was a further breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns
● There was no system in place for recording and monitoring complaints about the service.
● People told us they would speak to a staff member if they wanted to make a complaint and relatives said they would speak to the manager of the home.
● One relative told us they had never had information about how to make a complaint but they were confident that staff would address any complaints or concerns that they raised.
● The lack of systems for managing complaints meant the provider could not be assured that all complaints were addressed and learning was identified. This is an area of practice that needs improvement.

End of life care and support
● There were no end of life care plans in place for people at The Highviews, including for a person who had been prescribed end of life medicines in case their health deteriorated suddenly.
● This meant that staff would not have all the information they needed about people's wishes and needs at the end of life. This is an area of practice that needs improvement.

Inadequate

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There was a lack of effective systems for oversight and governance, this meant the provider could not be assured of the quality and safety of the service.
- There were no auditing systems in place to ensure that risks were identified, assessed and managed effectively. This meant that shortfalls in risk management had not been identified and addressed. For example, systems for monitoring fire safety were ineffective and had not identified hazards in the home. Following the inspection, we informed the fire and rescue service about our concerns regarding lack of staff understanding about fire risks at the service.
- There was no system in place for auditing medicine administration. This meant that errors were not being investigated and the provider could not be assured people were receiving their medicines as prescribed or that lessons were learned from mistakes.
- There was no system in place to report incidents and accidents. Staff said they had completed incident and accident forms previously, but the new provider had not yet implemented a system for recording and monitoring incidents. This meant there was no oversight of incidents and the provider could not be assured of sufficient investigation of causes, that lessons were learned and improvements implemented.
- Poor record keeping called into question whether incidents had been recorded and reported in line with the duty of candour.
- Records were not up to date and complete. For example, risk assessments for people were not available for staff because they had been removed from the service to be updated. Some care plans were not detailed, for example a person needed support from 2 staff to move using a hoist. Their care plan did not provide details about how to achieve this safely, including how to manage their oxygen equipment during this procedure. This meant staff did not have all the information they needed to provide safe care.
- Records of care provided were not complete. For example, staff did not record when they supported people to change position. This meant that there was not a complete and contemporaneous record of the care provided to people.
- There was a heavy reliance on staff knowledge of people and verbal communication between staff. For example, when staff came on duty important information was often shared verbally and not recorded. A staff member told us, "We do a verbal handover, nothing's written down but if it's an agency staff member we explain what they need to do before going off duty." This meant there was a risk that information could be forgotten or misinterpreted.

● There was not an effective system for monitoring recruitment checks for staff. This meant that the provider could not be assured that all staff were suitable to work with people.

The provider had failed to establish effective systems and processes to ensure the safety of the service, to maintain accurate records, and to evaluate and improve practice. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The service was not adequately resourced to ensure staffing levels were appropriate to meet people's needs and to achieve positive outcomes. Systems for assessing and monitoring people's needs were not robust and this meant the provider could not be assured that staffing levels were adequate to meet their needs.

● The quality of risk assessments and care plans did not support a personalised and outcome-based approach. This meant that people were not supported with a planned approach that focussed on their quality of life.

● There had been a lack of leadership and the service had been without a registered manager. A deputy manager had been in charge on a day-to-day basis but they had been the only member of permanent staff. This meant they were not able to fulfil the managerial aspects of their role because they were providing care to people.

● The lack of permanent staff and management at the service meant people were not receiving the quality of life that they should expect. There were few opportunities to be part of the community or to follow interests and people were not supported to achieve positive outcomes, including improving their independence because there were not enough staff to support them.

The failure to establish effective systems to assess, monitor and improve the quality of the service was a further breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had recently recruited a manager who had been in post only 9 days when we inspected. They had already undertaken a review of the service and had identified many of the concerns that we found. They showed us their service improvement plan which indicated how they would be prioritising actions to make the necessary improvements at the service. This gave us some reassurance that suitable steps would be taken to ensure the safety of people living at The Highviews.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

● There had been a lack of engagement with people, their families and staff. The new manager told us involvement was a priority and they had already started to make changes, including having meetings with people. One person told us there were plans for them to join a local art club and said, "I have always wanted to do mosaics." Another person told us they enjoyed shopping and said, "Everyone will be going shopping once a week themselves, to choose their own things." People seemed pleased and excited to have been involved in developing a shopping list and choosing food for a new menu.

● Relatives told us staff kept them informed about changes at the home and any matters of concern. One relative said, "Communication is good, they always call me if there are any issues." A person told us they had been involved in making colour choices for the recent redecoration of the home.

Working in partnership with others

● Staff were focussed on supporting people with their daily needs, including ensuring appropriate referrals

were made to health and social care professionals.

● Records confirmed that staff were working effectively with others to support people. A staff member told us about 1 person who was waiting for a date for an operation. They described how staff would support the person to plan for their admission and for their care following the operation to ensure they had a positive experience and that health care staff were aware of the person's needs.

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 9 HSCA RA Regulations 2014 Person-centred care There was a failure to provide a personalised service that was responsive to people's needs and preferences, and a failure to ensure people's social needs were met.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The lack of risk assessments, failure to manage risks to people, failure to monitor incidents and failures in systems for managing medicines safely meant that people were at risk of avoidable harm

The enforcement action we took:

We issued a warning notice requiring the provider to be compliant within a given time scale.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish effective systems and processes to ensure the safety of the service, to maintain accurate records, and to evaluate and improve practice. The provider had failed to establish effective systems to assess, monitor and improve the quality of the service.

The enforcement action we took:

We issued a warning notice requiring the provider to become compliant within a given timescale

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure there were sufficient suitable staff deployed to meet people's needs. There was a lack of staff support and failure to ensure suitable training that was relevant to people's needs.

The enforcement action we took:

We issued a warning notice requiring the provider to be compliant within a given time scale.