H G M MEXBOROUGH LLP

Highgrove Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service caring?	Inadequate

Overall summary

The inspection took place on 20 July 2015, and was unannounced. We carried out this, focused, inspection in response to concerning information we had received about the home from the local authority's safeguarding procedures, and from a notification that the provider had submitted to us. The home was previously inspected in February 2015, and June 2015. Breaches of regulations were identified during these inspections, and we are currently taking action against the provider in relation to this. We will report on this action at a later date.

Highgrove Care Home is a 78 bed nursing home, providing care to older adults with a range of support and care needs. At the time of the inspection there were 47 people living at the home.The home is divided into four discrete units.

Highgrove Care Home is located in Mexborough, a small town in Doncaster, South Yorkshire. The home is known locally as Highgrove Manor. It is in its own grounds in a quiet, residential area, but close to public transport links.

At the time of the inspection, the service did not have a registered manager, although it was required to do so. 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 and associated Regulations about how the service is run.

The home had received a comprehensive inspection in February 2015, and was rated at that inspection. A follow up inspection took place in June 2015. This inspection, of

Summary of findings

July 2015, took place to look at the fire safety arrangements and the way that people experienced care. The ratings referred to in this inspection are those awarded in February 2015.

During the inspection, we found that staff did not always interact well with people, although we noted that staff ensured they were present with people as much as possible. We observed that staff understood people's needs well, although did not always meet these needs.

We checked the arrangements for fire safety in the home, and found that the provider had engaged an external agency to give formal advice on fire safety. However, the external agency's written advice had only just been received at the time of the inspection and therefore plans to address shortfalls were only just being introduced. Staff gave us positive feedback about the fire safety training they had received, but we noted that good practice was not always being adhered to.

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 always safe.

Most, but not all, staff had received training in fire safety. However, we observed that best practice was not always followed. The provider had engaged an external professional to carry out a fire safety assessment, but the written report had only just been received and therefore actions to address shortfalls had not yet been implemented.

The rating referred to in this report was awarded in February 2015, and will be reviewed when we next carry out a comprehensive inspection at the home.

Is the service caring?

Inadequate 

The service was not always caring

Staff we observed were kind, and appeared to know people's needs well, but staff did not always engage with people; people we observed were often unoccupied. Staff were patient and gentle when supporting people to move around the home, but we observed that at times staff did not practice effective moving and handling techniques.

The rating referred to in this report was awarded in February 2015, and will be reviewed when we next carry out a comprehensive inspection at the home.

Highgrove Care 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 checked whether the provider is meeting specific requirements of the regulations associated with the Health and Social Care Act 2008. This inspection did not provide an overall rating under the Care Act 2014.

The inspection was unannounced, which meant that the home's management, staff and people using the service did not know the inspection was going to take place. The inspection visit was carried out on 20 July 2015. The inspection was carried out by two adult social care inspectors.

During the inspection we spoke with five staff, the home's owner, a senior member of the provider's management team and eight people who were using the service at the time of the inspection. We checked records relating to the management of the home, team meeting minutes, training records, medication records and records of quality and monitoring audits carried out by the home's management team and members of the provider's senior management team.

We observed care taking place in the home, and observed staff undertaking various activities, including handling medication, supporting people to eat and supporting people to participate in activities. In addition to this, we undertook a Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We focused mostly on one area of the home, as we had received concerning information in relation to this area. We also contacted the local authority to gain their view of the service provided. Additionally, we reviewed records we hold about the provider and the location, including notifications that the provider had submitted to us, as required by law, to tell us about certain incidents within the home.

Inadequate

Is the service safe?

Our findings

We looked at whether the service was safe during our inspection of February 2015. We identified a number of regulatory breaches, and rated the provider as "inadequate" in relation to this key question. A further, follow up inspection was undertaken in June 2015, and again, regulatory breaches were identified. At the inspection of 20 July 2015, we looked specifically at the arrangements for fire safety in the home as the home had recently reported to us that a fire had occurred in an outside area which may have had an adverse impact on one of the people using the service.

We found that most, but not all, staff had received training in fire safety. We asked one staff member about this training and they said it had given them a good understanding of this issue. They described that the trainer had tailored the training to the physical environment of the home to help them better understand their responsibilities. We checked training records against the details of the staff who were on duty when the recent fire occurred, but found that only a minority of staff who had been on duty had received this training. We asked the provider's nominated individual about this, and they told us that training was scheduled imminently.

We checked records of fire drills, and found that drills took place regularly. Our own records showed that a fire drill had taken place during our last inspection of the home, in June 2015. However, records of drills showed that none of the staff who had been on duty at the time of the recent fire had participated in any recent drills. The nominated individual told us that they were taking steps to address this.

The provider had contracted an external fire safety advisor to undertake an assessment of their fire arrangements. We saw a copy of this report and identified that a number of requirements and recommendations had been made. However, although the assessment had taken place in May 2015, the provider had only recently received a copy of the report. The nominated individual told us that steps were underway to address the identified shortfalls, but this work had not yet been completed due to the report only recently being received.

We discussed the recent fire with the nominated individual. It had taken place four days prior to the inspection, in an outside smoking area where combustible materials had been left. There were concerns that one of the people using the service had suffered smoke inhalation, and medical attention had been sought. The nominated individual described that safety checks of this area were being implemented, however, these were not yet documented. The nominated individual contacted the Commission shortly after the inspection to confirm that this work had been completed.

We looked at the provider's risk assessments in relation to fire safety. Most areas of the home had been assessed, and these assessments were regularly checked to ensure they were up to date and being adhered to. However, no risk assessment had been carried out in relation to where the fire had broken out. The nominated individual told us this was in the process of being addressed as part of their response to the fire.

We carried out a visual inspection of the premises, and found that fire extinguishers were placed at regular points around the home, and the ones we checked had been recently serviced. There was fire safety information available to all staff in communal areas, and fire safety notices where relevant. However, these safety notices were not always being adhered to. For example, we noted a number of fire doors had been propped open with either door wedges or furniture. This meant that, in the event of a fire, these doors would not close. We discussed this on the day of the inspection with the nominated individual. They told us that a programme was under way to replace these doors with the self-closing type, so that doors could remain open but would automatically close in the event of the fire alarm being sounded. They told us, however, that this programme had not yet been completed.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The rating referred to in this report was awarded following the inspection of February 2015. This rating will be reviewed when we next carry out a comprehensive inspection at the home.

Inadequate

Is the service caring?

Our findings

We looked at whether the service was caring during our inspection of February 2015. We identified a number of regulatory breaches, and rated the provider as "inadequate" in relation to this key question. A further, follow up inspection was undertaken in June 2015, and again, regulatory breaches were identified. During the inspection of 20 July 2015, we focused specifically on one area of the home as we had received concerning information from a visiting professional.

We carried out a Short Observational Framework for Inspection (SOFI) during the morning period. Throughout the SOFI, we noted that while there were enough staff to meet people's physical care needs and chatted with people on a one to one basis, there were some people who were not engaged in any meaningful activity for long periods during the morning and most just sat, or slept, in their chairs. We were told that the activity worker was not at work that particular day.

We observed people who used the service and staff in the lounge on the unit for just under four hours. There was at least one staff member present with people while they were in the lounge. One staff member explained this was to meet people's needs and to ensure their safety. While in the lounge, staff engaged with people and asked them if they were all right. They sometimes sat and chatted with people on an individual basis. However, during this time there were seven or eight people in the lounge at any one time, and five spent most of their time unoccupied or sleeping.

All staff members we spoke with were relatively new in post, however, they were all very aware of people's needs and preferences and had built positive relationships with people.

All were polite, kind and gentle in their approach and communicated well with people. One staff member demonstrated to us that, because some people often looked down while seated, staff needed to place themselves at a level where they could gain eye contact to get people's attention before starting a conversation.

Staff demonstrated that they knew people's needs well. For instance, all four staff we spoke with were aware that one person was nervous when being lifted in the hoist. We saw different staff use the hoist to lift this person on two occasions and they all took time to explain and reassure the person. They used strategies to distract the person and help put them at their ease. However, we did note that when using the hoist to move people, staff did not plan ahead, and consequently they often had to move furniture out of the way during the process, and this could add to any stress people experienced during the process.

We sat and chatted with people in the dining room, while they waited for their lunch. Staff told us there were two choices of meal and people could also choose other things, such as salad. One person we spoke with said; "The food is very nice."

People were offered clothing protectors, staff approached people in a gentle way when providing these. They were aware that one person liked to put theirs on themselves and encouraged them to do this, to promote their independence. Two staff members explained there were pictorial menus, so they were able to show the menu to people to help them choose which meal they wanted, or they would show the person the different, plated meals if appropriate.

We noted that people waited for more than three quarters of an hour for their lunch, while sitting at the tables in the dining room. We were told by staff and people using the service that this was very unusual. One staff member explained that the menu included fresh omelettes that day and this had contributed to the delay. We discussed this with the nominated individual and they confirmed that this was an exceptional circumstance.

We checked three people's care records, including records which showed how much fluid people had received during the day. We found that staff had consistently completed the forms. However, we found the forms needed to be improved to ensure that people received the care they required. The way the forms were set out made it difficult to monitor the quantity of fluid that people had had to drink and none of the overall totals had been completed for any for the records we saw. No information was included about how much fluid staff should aim to encourage each person to drink and we found there were occasions when it was recorded that people had received less than 1litre of fluid in a twenty four hour period. The current best practice guidance for hospitals and healthcare services from the National Patient Safety Agency states

Is the service caring?

that, although there is no agreed recommended daily intake level for water in the UK, a conservative estimate for older adults is that daily intake of fluids should not be less than 1.6 litres per day.

We looked at the 'turn' charts for three people who used the service. These were completed by staff to record and monitor when people had been helped to turn to a different position in bed, to help prevent pressure ulcers. No information was included on the charts about how often each person should be turned in any given timescale. This made it difficult to monitor whether people were receiving the correct care without having access to the detail of their care plans. We discussed this with a member of nursing staff who told us they had also identified that the charts being used needed improvement and they had already discussed this with the home manager as they were happy to undertake the improvement work. However, at the time of the inspection, this improvemet work had not yet been completed.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The rating referred to in this report was awarded following the inspection of February 2015. This rating will be reviewed when we next carry out a comprehensive inspection at the home.