Randomlight Limited

Heightside House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Heightside House Nursing Home is a residential care home which provides accommodation, nursing care and personal care for up to 78 older people and younger adults with mental health support needs. Accommodation is provided in four units; The House, The Mews, Close Care and The Gate House. The House is an adapted building, over four floors and incorporates the High Dependency Unit, The Mews is purpose built and consists of one six bedded unit, shared bungalows and flats, Close Care is purpose-built and includes a seven bedded unit and a bungalow and The Gate House is an adapted building and can accommodate up to three people. No-one was living in The Gate House at the time of our inspection. There is also a separate activities centre. At the time of the inspection 53 people were living at the service.

People's experience of using this service and what we found
People's medicines were not always managed safely; we found a number of shortfalls in medicines practices at the service. People told us they felt safe living at the home and there were enough staff available to meet their needs. Staff supported people to manage risks to their health and wellbeing and understood how to protect people from the risk of abuse. The provider followed safe recruitment practices when employing new staff. Staff followed safe infection control procedures and wore appropriate personal protective equipment (PPE), to protect people from the risk of infection and contracting the COVID-19 virus. The safety of the home environment was checked regularly.

The ongoing issues with medicine management at the service, meant that the provider did not have effective processes in place to monitor the quality and safety of the service and ensure improvements were made when needed. The service worked in partnership with community agencies to ensure people received the support they needed. People, relatives and staff felt the service was managed well. People's views were sought about the service; however, it was not always clear what action was taken in response to the feedback they provided. We have made a recommendation about ensuring people's views about the meals provided at the home are considered and acted upon. We will follow this up at the next inspection.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 17 February 2020). At that inspection we found two breaches of regulation relating to the management of people's medicines and a lack of effective systems to monitor and improve the quality and safety of the service. The provider completed an action plan after that inspection to show what they would do and by when to improve. At this inspection we found that not enough improvement had been made and the provider was still in breach of those regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last six consecutive inspections.

Why we inspected
We undertook this focused inspection to check that the provider had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions of Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

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.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and take the action required to keep people safe and to hold providers to account where it is necessary for us to do so.

At this inspection, we have identified breaches in relation to the unsafe management of people's medicines and the lack of effective systems in place to ensure the quality and safety of the service. Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Heightside House Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by an inspector and a medicines inspector.

Service and service type
The service is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send to us to give us key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with three people who lived at the service, three care staff, two nurses, the hotel services manager, the registered manager, the deputy manager and the operations manager. Following our visit we spoke on the telephone with three people's relatives, to gain their feedback about the support provided at the service.

We reviewed a range of records, including two people's care records, a selection of medicines records and two staff recruitment files.

After the inspection
We reviewed a variety of records related to the management of the service, including policies and audits. We contacted three community health and social care professionals for their feedback about the support provided at the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

At our last inspection the provider had failed to ensure people's medicines were managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● The provider had made limited improvements to the management of people's medicines since our last inspection. Fewer people had missed doses of their prescribed medicines because there was no stock available, however, we found this was still the case for two people.
● Information about "when required" medicines was not always available to guide staff, or was not personalised. Medicines prescribed with a choice of dose, did not always include information to guide staff about which dose to choose. Information about how to manage people's diabetes was not always available to ensure it was treated safely.
● Medicines records failed to show that all medicines were given as prescribed. Creams records were not always available or did not always show that they had been applied properly. Information about thickeners (used to make liquids safe for people to drink) was not always available to guide staff or documented when it had been administered. Time specific medicines were not always given as prescribed.

We found no evidence that people had been harmed, however, the provider had failed to ensure that staff were managing people's medicines safely. This placed people at risk of harm. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had completed the necessary training and been assessed as competent to administer people's medicines safely. People living at the home and relatives were happy with how medicines were managed.

Systems and processes to safeguard people from the risk of abuse
● The provider had systems to protect people from abuse and avoidable harm. The staff we spoke with understood how to protect people from the risk of abuse and the action to take if they had any concerns.
● People felt safe living at the home and when staff supported them. They told us, "I feel safe here. I haven't had any issues. If I'm worried about anything I can talk to the staff" and "I feel safe. There's always someone [staff] around when you need them. The staff treat me well."

● The manager had taken appropriate action when safeguarding concerns had been raised about the service. The local authority had investigated concerns raised and most had been unsubstantiated. Where improvements were needed, these had been addressed by the registered manager.

Staffing and recruitment
● The provider recruited staff safely, to ensure they were suitable to support people living at the service. Some minor improvements were needed to recruitment documentation and the registered manager addressed this during the inspection.
● People living at the home and relatives we spoke with were happy with staffing levels at the home. They felt there were enough staff available to meet people's needs and provide support when it was needed it.
● Two care staff were happy with staffing arrangements at the service. However, one staff member told us, and we saw in the staffing rotas we reviewed, that one of the units was sometimes understaffed, according to the staffing tool used by the home. The registered manager told us this was due to a staff vacancy and advised that they had recently recruited an additional staff member. He told us staff on another unit had provided support when needed to ensure people received safe care.

Assessing risk, safety monitoring and management
● The provider had processes in place to assess, monitor and manage risks. Staff supported people to manage risks to their health, safety and wellbeing effectively. People's risks were assessed and reviewed regularly. Risk assessment documentation guided staff on how to support people safely and was updated regularly or when people's needs or risks changed. Detailed risk assessments and care plans were in place to guide staff on how to support people with their mental health support needs.
● The provider had systems to manage accidents and incidents appropriately. Staff took appropriate action when accidents or incidents took place and completed the necessary documentation. The registered manager notified CQC and the local authority about incidents when appropriate.
● The provider ensured regular checks of equipment and the home environment were completed, including lifting equipment, fire safety and water checks, to ensure it was safe. During our inspection we found that a small number of windows did not have restrictors fitted. We were informed they had been removed by decorators recently when the window frames were painted and it was an oversight that they had not been refitted. It was addressed immediately. The registered manager advised he would ensure that window restrictors were checked regularly in future, which would be documented.

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 meeting shielding and social distancing rules.
● 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 accessing testing for people using the service and staff.
● 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 could be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● The provider had systems to analyse incidents, complaints and safeguarding concerns and make

improvements where needed. The manager shared lessons learned with staff.

● Further improvements were needed to the management of medicines practices and errors at the home to ensure that people received their medicines safely.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider did not have effective processes in place to ensure the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider's systems for monitoring and ensuring the quality and safety of the service needed improvement. Following the last inspection, the provider had submitted an action plan to CQC, detailing the improvements they would make to the management of medicines at the home. At this inspection we found that regular audits of medicines had been completed, however, the necessary improvements had either not been made or maintained. Some of the shortfalls we identified during our inspection had been found during the home's audits and we found evidence that many had been addressed with staff. However, unsafe medicines practices and medicines errors continued at the home.

We found no evidence that people had been harmed, however, the provider had failed to ensure the quality and safety of the service. This placed people at risk of harm. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider and manager understood their roles and regulatory responsibilities. The registered manager was responsible for the day to management of the home, with support from the deputy manager. The operations manager visited the service regularly. The management team completed a variety of regular audits and checks, however, it was not always clear from the audits, the action taken to address any shortfalls found.
● The home had an improvement plan, which included the ongoing issues with medicines management. Actions taken included staff training, supervision and disciplinary action. In addition, from June 2021, meetings were to be held three times a week to review medicines records and ensure actions from audits were completed. The service had also sought support from the NHS Innovation Agency, which can assist care homes with quality issues. They were due to visit the home in the near future.

● The manager had submitted statutory notifications to CQC about people using the service, in line with current regulations. A statutory notification is information about important events which the service is required to send us by law.

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

● We found that the home had an inclusive culture, which focused on individualised care and achieving good outcomes for people. Management and staff treated people as individuals and involved people and their relatives in decisions about their care. One community professional told us staff at the home were nurturing and compassionate, and provided person-centred care and treatment, which supported people to develop positive coping strategies.

● Everyone we spoke with was happy with the support provided by staff and how the service was being managed. People living at the service told us, "The staff are very nice. I don't have any concerns but if I did, I'd speak to someone" and "I'm happy here. I have my own room, with my own things." Relatives commented, "The home's brilliant with [person]. She's well looked after, and the staff always contact me if there are any issues" and "I can't fault the staff at all. We've had no issues with the support provided. When [person] is unwell and I speak with staff, they always reassure me that they are aware and are addressing it."

● Staff were clear about the provider's aim to provide people with high-quality, individualised care. One staff member commented, "I've never seen anything bad happen here. I can see people getting better because they've had the right support."

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

● The provider had a duty of candour policy and management were aware of their responsibilities. No incidents had occurred that we were aware of, which required duty of candour action.

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

● The provider had processes to gain feedback from people and relatives about the support provided at the service. Residents' meetings took place regularly and people gave their feedback on a variety of issues, including activities, the environment and meals. Concerns had been raised about meals at a number of meetings and the operations manager's reports also referred to ongoing concerns raised about food. It was difficult to see what action had been taken or improvements made in response to this feedback. Some people had expressed concerns about the service's catering arrangements at the last inspection.

We recommend that the service seeks advice and guidance from a reputable source, to ensure people views about the food provided at the home are considered and acted upon, to ensure meals reflect their needs and preferences.

● Staff told us they found management approachable and supportive. Some felt that management should be more visible around the home. Their comments included, "We hardly see them but they're approachable. We're line managed by the nurses and they're all very approachable about anything" and "The management are fantastic. They listen, sort problems out and guide you, and the training is good."

● Staff questionnaires had been issued in July 2020 and 19 out of 80 staff had responded (23.75%). A summary of the results showed that the majority of the questions received positive responses. The summary included action taken by management in response to the feedback received.

Working in partnership with others

● The service worked in partnership with people's relatives and a variety of health and social care professionals to ensure people received the support they needed. These included social workers, GPs, community nurses, hospital staff and dietitians.

● One community professional who visited the service told us communication with staff was always very good. Another told us that they sometimes found it difficult to arrange reviews and actions agreed at reviews were not always completed in a timely way. However, the person they visited had built good relationships with staff and other people living there.

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
Treatment of disease, disorder or injury	The provider had failed to ensure that staff were managing people's medicines safely.

The enforcement action we took:

We issued a warning notice and required the provider to be compliant by 5 August 2021.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to ensure the quality and safety of the service.

The enforcement action we took:

We issued a warning notice and required the provider to be compliant by 5 August 2021.