Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Highfield House

Manchester Road, Heywood, OL10 2AN

Tel: 01706624120

Date of Inspections: 01 September 2014
28 August 2014

Date of Publication: October 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Cleanliness and infection control	✖ Action needed
Management of medicines	✖ Action needed
Staffing	✖ Action needed

Details about this location

Registered Provider	Eagle Care Homes Limited
Overview of the service	Highfield House is a large detached house situated close to the centre of Heywood. The home is registered to provide accommodation and personal care for up to 25 people.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We carried out a visit on 28 August 2014 and 1 September 2014, observed how people were being cared for, talked with people who use the service and talked with staff. We reviewed information given to us by the provider.

What people told us and what we found

We visited Highfield House due to information of concern we had received about the service.

Since our last routine inspection undertaken on 9 July 2014 we had been contacted by numerous people including a health care professional and a relative. They raised concerns about staffing levels, staff qualifications and experience, particularly on the night shift, as well as medication and infection control practices. We also considered information we had received from the Infection Control Team following their inspection at the home.

We carried out two out of hours visits to the home. During our first visit on the evening of Thursday 28 August 2014 we spent time talking with the nominated individual (NI) the named person with overall responsibility for the home on behalf of the part of the owners, the registered manager from Highfield Manor and looked around parts of the home.

On our return visit on the morning of Monday 1 September 2014 we spent time talking with people who used the service and staff, observing how people were cared for, looking at records and at parts of the building.

We considered all the evidence we had gathered under the outcomes we inspected. We used the information to answer the five questions we always ask: Is the service safe? Is the service effective? Is the service caring? Is the service responsive to people's needs? Is the service well-led? Below is a summary of what we found.

Safe

Medication returns were not securely held and people did not always receive the medication that had been prescribed for them by their doctor.

We saw audit records that raised concerns about the competence of staff to carry out their roles safely and effectively.

Effective

Procedures introduced to remove offensive waste had created a significant malodour problem in the shower room, which most people at the home used.

There were not always enough of the right types of incontinence pads accessible to staff and available for people to use during the night.

Caring

We saw that care staff were polite and helpful to people. Those people able to communicate their needs and wishes were seen to enjoy a good rapport and humour with staff.

Responsive to people's needs

We saw that progress had been made to address the issues raised in a recent audit by the local infection control team to improve practices.

We saw that action had been taken to recruit staff into vacant staff posts at the home.

Well-led

The home had no registered manager. This is a breach of the provider's registration. The home had experienced a change of personnel within the management team which had impacted on the management of the service. We were made aware that it was the intention of the area manager to register with us as the full time manager of Highfield House.

A staff member told us that the home "needed a full time manager".

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 23 October 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Cleanliness and infection control ✖ Action needed

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

People were not protected from the risk of infection because adequate systems were not in place.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We received information of concern about the level of cleanliness at Highfield House and the lack of availability of cleaning equipment and also disposable protective items such as aprons and gloves for staff to use when supporting people with personal care. They also informed us that there were not always enough of the right type of incontinence pads accessible to staff and available for people to use during the night.

Prior to our visit we had been sent a copy of the inspection carried out by Rochdale MBC Infection Control team in May 2014. The home was assessed as 67% compliant. Improvements were needed to the environment, resident's rooms and waste management.

We visited the home at 7.30pm on the evening of 28 August 2014. The area manager and registered manager of Highfield Manor (the organisation' sister home next door) told us that the action required would be completed in time for the next planned infection control inspection in October 2014.

An action plan had been draw up detailing what action was to be taken. A copy of the report was sent to the CQC following our inspection. The action plan we received gave information about the progress that had been made to make the improvements identified by the infection control team. This included the purchase of new chairs which were easier to keep clean and an offensive waste contract had been put in place.

We looked at a number of communal areas of the home which included both dining areas and lounges. No malodours were detected. We were told that new chairs had been purchased by the owners of the home that would be easier to keep clean. These had arrived by the time of our second visit to the home.

We also looked at a number of toilets and bathrooms. These were seen to be clean, tidy and no odours were detected. We also saw that to help protect people from the spread of infection paper towels and liquid soap, were available for people to use. We also saw that plastic boxes were situated in the bathroom and shower room that contained disposable gloves and aprons to use to help prevent the spread of infection.

We went down into the cellar to look at the storage and availability of cleaning equipment. We saw that cellar door was locked and could only be accessed by staff. The cleaning equipment we saw was kept in a steel cabinet under a stone stairwell. We saw that incontinence pads were kept in a locked room. In this room oxygen that had been used by a person who had lived at the home was also being stored and there were a significant number of items in the room that included paperwork. Following our visit we asked the local fire officer to visit the home. The oxygen had been removed.

On our return visit to the home on Monday 1 September 2014 we asked the night staff on duty about the cleaning tasks and about accessibility to cleaning materials and disposable protective aprons and gloves. They told us that there had been times when staff had brought in cleaning products but the situation had improved recently. They said there was usually enough time to carry out the cleaning tasks during the night.

They told us there were problems at times during the night when staff did not have access to the right type of incontinence pads to meet people's individual needs. This meant that some people were being disturbed more frequently throughout the night to be changed. Night staff knew where the incontinence pads were stored but did not know where the key was to access the room.

We talked to staff about the arrangements for people to have a bath or a shower. We were told that one bathroom had been out of use for some time and the bathroom upstairs was not used very often. The ground floor shower room was used the most often. We saw that the shower room had a large 'wheelie' type yellow offensive waste bin for the disposal of incontinence pads. The bin was not air tight and three quarters full with incontinence pads that were not individually bagged which meant a significant unpleasant odour was being released into the shower room.

We saw that a specialist bath in one bathroom was not in use. There was a note on the door which stated hurry up and get this fixed. We were told by the NI the bath kept breaking down because of the narrow space it was fitted into and there had been difficulties in getting parts for it. Other equipment was stored in the room.

The laundry was situated in the cellar. There were no designated laundry staff and the care staff team were responsible for managing all the laundry, which included bedding. We were told that red bags were used to transfer soiled items to the laundry and this was later confirmed by staff. There was a significant amount of unused items in the laundry room which included the old chairs removed from the two lounges.

We spoke with the cleaner. They showed us where the cleaning equipment was stored and that it was accessible for them to use. There were instructions on the wall for the use of colour coded items such as mops, buckets and clothes. There was one cleaner who worked at the home and a second post that was vacant, though a potential candidate for the post had been recruited.

We looked at the cleaning arrangements in the kitchen. The kitchen appeared to be clean

and tidy and records of cleaning undertaken by the cooks were kept. We saw that colour coded chopping boards and knives were available for kitchen staff to use. A check of fridge and freezer temperatures was taken and recorded every day to ensure that food was being kept correctly.

We were told that the home had recently had a new fridge installed in the kitchen. On closer inspection of the fridge we saw that there was a large pool of water in the bottom of it which suggested there was a problem with it.

We saw that when a spillage occurred swift action was taken to clean it up and staff used a sign to warn other people that there was a hazard. At meal times we saw that people wore black cotton aprons and in some cases hats, as opposed to disposable gloves and aprons for personal care, when serving and supporting people to eat their meals.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We had been made aware by a health care professional about concerns relating to a person not having some medication prescribed for them in stock. This issue was under investigation by the local safeguarding team at the time of our visit.

We looked at medication practices at the home on our return visit on Monday 1 September 2014.

We saw that two medication trolleys were kept in the dining room. The trolleys was locked and chained to the wall. We were told by night staff that medication was not given out by them and they did not have access to the keys for medication. We were told that only team leaders who had received the relevant training had access to medication.

We looked at some medication records and saw that there was a photograph available to help ensure the correct identification of people and allergies to medication were also noted.

Medication administration record sheets (MARs) were in place. The MARs were pre-printed sheets and sent with a month's supply of medication from the pharmacist. We saw where that were handwritten entries had been added to the MARs these had been double signed to help ensure what had been written was correct.

We observed a team leader administer medication. They wore a disposable protective apron, not distinguishable from personal care, and used gloves were people required support to take their medication orally. We saw the team leader signed for the medication after it had been given to each person. Water was available to help people take their medication. The medication trolley was always kept locked when the team leader left it to administer the medication.

Controlled drugs were stored in the downstairs office in a locked medication cabinet within a locked cupboard. We went with two staff to this room to collect the medication. We saw

that they checked the medication and double signed for it in the controlled drugs book.

We saw that a fridge used for storing medication was also held in this room. We were told that a record was kept of the fridge temperature.

We also saw in this room medication which was waiting to be returned to the pharmacy. We were told that it had been there for over a week. Although this medication was in a lockable room it was not securely held which meant other people had access to it. We saw that within the returns medication there was a lot of medication for one person being sent back to the pharmacy. We were told that this was because the person was not up at certain times that they should receive their medication.

We looked at the team leader communication book. We saw that the registered manager from Highfield Manor had found over recent months a number of issues during their checks which related to controlled medication not being signed for, medication having to be destroyed because it had not been put into the fridge and medication seen to have been left lying around the home.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

During our inspection on the 28 August 2014 we discussed the staffing situation with the area manager and registered manager from Highfield Manor (the organisation's sister home next door). Both acknowledged that there had been some changes in the team. We were told that further recruitment had taken place to fill the vacancies at Highfield House and a second home owned by the provider next door. We were told that any staff employed to work for the provider was contracted to work across both homes.

When we arrived at the home on Thursday 28 August 2014 the NI was on duty. The NI told us this was to cover the 5 – 9pm shift. The registered manager from Highfield Manor joined us a short time later. We discussed with them some of the concerns raised with us

We were told that ten members of the staff team had left the home since January 2014. This included the person who managed the home and two team leaders. The home was also carrying three care staff posts where staff members were on long term sick leave but had failed to produce the necessary certification from their doctor to confirm this.

We were told by the area manager that nine people had been interviewed and they were due to come into the home to complete their criminal record check to the Disclosure and Barring Service (DBS).

We were told that the home did not use outside agency staff and covered vacancies with additional hours for permanent staff who worked part time or bank staff from within the organisation. On call arrangements were in place with either the area manager or registered manager of Highfield Manor being contactable at any time.

The home had been without a manager registered with the Commission Quality Commission (CQC) for some time. This is a breach of the provider's registration. At the time of our visit management support was being provided by the area manager who was also the nominated individual (NI) for five homes, the registered manager of Highfield Manor (the organisation's sister home next door) and a team leader who usually worked at Highfield Manor. We were made aware that it was the intention of the area manager to

register with us as the full time manager of Highfield House. A staff member we spoke with said they thought that the home needed a "full time manager."

At our return visit on Monday 1 September 2014 at 7am we found there were two members of night staff on duty supporting the 23 people who were living at the home. One night carer was from another home within the organisation's group from which they were working their notice. The other night carer had worked at the home for two years and only worked at Highfield House.

Night staff said that they thought there were enough staff members on duty to carry out their role most of the time and dependent on people's changing needs. However they thought it would be beneficial for people who used the serve to have an additional member of staff on duty between 7am and 8am to supervise and support people who were already up whilst night staff continued to support others in their bedrooms. We were told that there was no pressure on night care staff to get people up before they were ready to.

On the morning of our second visit to the home on Monday 1 September 2014 a staff member from the day shift rang in sick and so night staff stayed on longer until another member of staff arrived. The staff team for the morning comprised of two team leaders and a member of the bank staff team.

We saw in the night communication book that one night carer had worked 16 out of a possible 20 night shifts and also that domestic staff had covered a number of night shifts.

We had numerous concerns about information we saw in communication records about issues relating to practices at the home. For example the stand aid needed to support some people to move safely was broken. The care staff team were using different methods to transfer people such as using a different piece of equipment or additional staff. However communication books made it clear that there was a stand aid available for use that could be brought over from Highfield Manor next door. We also saw that the Police had been called to the home on one occasion and we do not appear to have been notified about this incident. This is a statutory notification that the provider is required to send to us.

The information also made references to other breakdowns in communication and the team meeting minutes we received suggested that there was some tension and unhappiness with the staff team.

We saw information that showed that internal training in adults at risk, moving and handling, dementia care, challenging behaviour, first aid awareness, infection control, food hygiene, fire safety and where appropriate medication training would be available for staff to attend between Monday 6 October through to Tuesday 21 October. These were in the main one hour sessions facilitated by the registered manager from Highfield Manor using DVDs and exam papers which were said to be externally marked.

Over our two visits we saw that people appeared happy and well cared for and the atmosphere at the home was calm and relaxed. We spoke with seven people and observed staff interactions with other people who were not able to give us their views and opinions of the service they received. We saw that care staff were polite and helpful to people. Those people able to communicate their needs and wishes were seen to enjoy a good rapport and humour with staff.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: People were not protected from the risk of infection because adequate systems were not in place. Regulation 12(2)(c)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The registered person must protect service users against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purpose of the regulated activity. Regulation 13
Regulated activity	Regulation
Accommodation for persons who require nursing or personal	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**

This section is primarily information for the provider

care	**How the regulation was not being met:** In order to safeguard the health safety and welfare of service users the registered manager must take appropriate steps to ensure that at all times there are a sufficient number of suitably qualified, skilled and experienced person's employed for the purpose of carrying on this regulatory activity. Regulation 22

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 23 October 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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