Tamhealth Limited

# Highfield Care Home

**Inspection report**

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## Ratings

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

## Overall summary

This inspection took place on 5 and 6 February 2015 and was unannounced.

Highfield Care Home provides nursing and personal care for up to 49 older people, some of whom were living with dementia.

The service had a registered manager in post since September 2014. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had appointed an interim manager to manage this service with support from a senior management team until a permanent manager is recruited to post.

CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually

# Summary of findings

to protect themselves or others. At the time of the inspection we found that not all applications had been made to the local authority in relation to people who lived at Highfield Care Home however these were later completed subsequent to our inspection.

People said they felt happy and safe at the home and staff treated them with kindness, dignity and respect. Relatives were also positive about the care and support provided.

People and their relatives gave mixed opinions about staffing levels particularly during the busier times of the day.

Safe and effective recruitment practices were followed to check that staff were of good character, physically and mentally fit for the role and able to meet people's needs.

People received their medicines safely and had access to healthcare professionals such as GP's, dentists and chiropodists when required.

People were supported to take their medicines as prescribed and were supported where possible to administer these themselves.

We found that staff obtained people's consent before providing the day-to-day care they required. However, we found that people's consent had not been obtained in line with the MCA 2005 in all cases.

Staff were caring and attentive to people's needs and interacted with people in a warm and respectful manner. People were given choices in such areas as food, activities and where they wanted to spend their time. Staff respected people's privacy and their visitors were always welcomed at the home.

People were involved in planning their own care and staff were responsive to their needs.

People's care needs were reviewed regularly to ensure the agreed plan of care continued to meet their needs.

There were a variety of activities available in the home however not all people were able to access these.

People were encouraged and supported to raise concerns and the manager closely monitored and sought feedback about the services provided to identify areas for improvement.

The manager completed a range of quality audits to monitor the quality of the service provided, however people's care records were not always legible and easy to read.

# 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?**
The service was not always safe.

People told us they felt safe and well cared for.

People told us that there was not always enough staff available at peak periods in the day.

Staff members were confident and well informed about safeguarding adults and how they would report any suspicions of abuse.

Recruitment procedures were robust and aided the manager to employ people to employ people who able to safely provide care.

Medicines were stored and administered safely, however medicine records had not always been completed appropriately.

**Requires Improvement**

**Is the service effective?**
The service was not always effective.

People's freedom of movement was only restricted where absolutely necessary. However the requirements of the Deprivation of Liberty Safeguards (DoLS) and requirements of the Mental Capacity Act (MCA) 2015 were not always followed.

Staff received regular supervision and training which meant that people's needs were met by competent staff.

People were supported to eat a healthy balanced diet.

People's day to day health and support needs were met.

**Requires Improvement**

**Is the service caring?**
The service was caring.

People were looked after in a kind and compassionate way by staff who knew them well and understood their individual needs.

People and their relatives were fully involved in the planning, delivery and reviews of their care.

Care was provided in a way that promoted people's dignity and respected their privacy.

People had to access independent advocacy services.

**Good**

**Is the service responsive?**
The service was responsive.

**Good**

# Summary of findings

People told us they received personalised care that met their needs and took account of their preferences.

People gave mixed feedback about the social activities provided.

People and their relatives felt confident to raise concerns and had confidence they would be dealt with.

**Is the service well-led?**

Good

The service was well led.

People, their relatives and staff were very positive about how the home operated and told us they felt the manager was approachable, visible and responded to their feedback positively.

Staff told us they understood their roles and responsibilities and were supported by senior colleagues.

Measures were in place to identify and reduce risks and to monitor the quality of services provided at the home.

Systems were used to review and manage risks and drive improvement within the home. Incidents were monitored and reviewed and reported as required.

# Highfield 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 was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was carried out on 05 and 06 February 2015 by one Inspector and was unannounced. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that requires them to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we spoke with 16 people who lived at the home, six relatives, four staff members, the home manager and regional manager. We also received feedback from health care professionals, stakeholders and reviewed the commissioner's report of their most recent inspection.

We looked at care plans relating to six people and two staff files. We also carried out informal observations in communal areas of the home such as the lounge and kitchen dining room.

We carried out observations throughout the day and used the short observation framework tool (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their complex needs.

Requires Improvement

# Is the service safe?

## Our findings

People told us that they felt safe living at Highfield Care Home. One person told us, "I feel alright here, the staff are kind and look after us as their top priority." However, people and relatives gave a mixed responses with regard to sufficient staff numbers. One person told us, "If they're not on mealtimes they'll come right away." A second person told us, "They are short staffed and desperate to get more. At the busy times they say, be back in five minutes, then it's 15. It's hard if you need the toilet." One relative told us, "Staffing is a lot better than before, but at the busy times like meal times [Person] has to wait longer than is reasonable." Another person told us, "There's sometimes a wait for the toilet or pills."

Throughout our inspection we observed call bells ringing, and noted the majority of these were answered in a reasonable time. However, not all were answered swiftly, when people rang for assistance. This meant people experienced a delay, which was observed to be at busy times of the day such as during the morning. We spoke with one person who had waited over five minutes for staff to respond. They told us that they were agitated as they wished to get up, and the staff were busy, however, they also said they did not have any personal care needs that required immediate attention. People who used the service and their relatives were very complimentary about the staff and the manner in which they were cared for however, our observations confirmed that where staff were busy, people did experience a delay in receiving care.

Staff we spoke with told us that at times, they were extremely busy which meant they were not always able to spend as much time as they wanted with people. One staff member told us, "It's not all the time, but now and then, depending on the residents needs we can get a bit backed up. Don't get me wrong, we don't not help people, but sometimes they have to wait, and it upsets them a bit." A second staff member told us, "It's better lately, but everyone needs to pull their weight when we are busy, then we all get to spend time doing the nice things."

Individual activities were not always provided to people who were confined to their bed due to a lack of activity staff. Particularly on the upper floor we observed people lying in bed with no radio, television or reading material provided and who were bored with little to interest them. We spoke with one person who told us, "I get the care I need, but I would like staff to spend a little more time with me doing a cross word or listening to some music." A second person told us, "It's hit and miss depending on which staff are working. Sometimes they will come in a sit down for a while, other times they don't and I can't do much for myself now. I don't want to go downstairs for baking or sewing, but would like them to stop by and watch the television with me now and then."

We discussed these issues with the manager who acknowledged that the deployment of staff at busy times was an area they were addressing. They told us they had monitored staffing using a variety of tools to assess people's needs, and this had identified the need for a greater staff presence on the ground floor. They told us that when people moved from the upper floor to the communal areas downstairs, staff did not always accompany them. This meant there was a greater pressure on the ground floor staff for to assist a greater number of people. They have subsequently told us that since the inspection they have reviewed how staff are deployed and have made improvements, and that feedback received from people has been positive since our inspection.

During our inspection an immediate increase in staffing hours was also authorised for activity provision by the regional manager. The manager subsequently increased the hours of activity provision so that once activity staff have left for the day, care staff are able to continue to provide activities. They also implemented a plan of activities for the weekends to help those without visitors not to feel isolated. However, this had not been identified by the management team at the time of our inspection.

Staff we spoke with were all able to demonstrate a good understanding and awareness about recognising safeguarding matters and told us they would report any concerns to management without delay. Staff were clear about the local authority's responsibilities and knew the procedure to follow in reporting any concerns externally which included whistleblowing.

The provider had a comprehensive policy relating to safeguarding and whistleblowing and provided annual refresher training to staff in this area. We looked at the homes records of incidents and accidents and noted these were investigated and actions had been made appropriately. One staff member told us, "If anything happens to a resident we record it and then it is investigated by the manager, and if needed then we

Requires Improvement

# Is the service safe?

discuss it in our supervisions." Records of safeguarding and incidents confirmed that the manager had reviewed and reported incidences appropriately. The manager closely monitored the frequency and outcome of each incident, and reviewed these regularly with the regional manager.

We checked a sample of records for recently recruited staff and found that satisfactory references and criminal record checks had been undertaken before staff worked at the home. Where there were unexplained gaps in people's employment histories these had been explained satisfactorily.

We saw that there were suitable arrangements for the safe storage, administration and disposal of people's medicines. We checked a sample of medicines and found the required number of tablets tallied with the stock records. When medicines were no longer required they were returned to the pharmacy.

Staff told us they had received relevant training and regular assessments were undertaken to ensure their continued competency to administer medicines safely. People were encouraged to administer their own medicines where they were able to do so, and staff had completed the appropriate risk assessments to ensure it was safe to do so. However, we found that when people's medicines were manually hand written onto the Medicine Administration Records (MAR) , these were not always countersigned. This meant that a staff member may inadvertently record incorrect information relating to the administration of the medicine. We spoke with the management team about this during the inspection, and when we returned on 06 February 2015, all hand written entries had been reviewed and countersigned. This helped to ensure that people received their medicines safely and as prescribed.

Requires Improvement

# Is the service effective?

## Our findings

People told us that they felt the staff were sufficiently skilled to care for them. One person told us, "They are confident when hoisting me, and very gentle and kind when they do so. They always make sure they check with me that I am ready, and I always feel so well cared for."

Staff we spoke with told us they always sought a person's consent prior to assisting them with any areas of care. One staff member told us, "I wait until they tell me they are ready, never just assume, if that means I have to come back later then that's the way it is." One person told us, "The carers come in and check I am ready to be helped and always ask before doing anything, they are very respectful to me."

Staff we spoke with were knowledgeable about the requirements of the Mental Capacity Act and Deprivation of Liberty safeguards. Where people had the capacity to consent to their care and treatment we saw from their records they had signed to indicate their consent. For example we saw that where bed rails were used, the risks had been explained and the person had then consented. Where people did not have the capacity to consent to their treatment, we saw that people's relatives had been consulted.

However, the requirements of the Mental Capacity Act had not always been followed, and mental capacity assessments had not always been completed when required, or when people's care needs changed. We saw from records that relatives had not always been involved in the decisions relating to people's changing care needs. For example, one person who was deemed to have capacity had deteriorated and staff told us they no longer were considered to have capacity to make specific decisions. However, records relating to their changing care needs had not been reviewed to reflect these changes. When we returned on 06 February 2015 we saw senior staff members beginning to undertake assessments, however these had not all been completed.

We also found that where people were required to have their liberty deprived, staff had not completed and submitted the appropriate authorisation. We spoke with the manager about this, and they told us that they would review those people who required an MCA and DoLs and complete each one in turn. When we returned on 06 February 2015 we saw senior staff members beginning to undertake this, however it had not been completed. The manager subsequently submitted to us evidence that demonstrated they had completed this shortly after the inspection.

We saw two Do Not Attempt Resuscitation (DNAR) forms which had been completed appropriately which included a record of the discussion with the person, their next of kin and a health professional.

Staff told us they received regular one to one supervision with their line manager. They said in addition they undertook group supervision which they said was beneficial. One staff member told us, "We have the formal supervision where we talk about how I am getting on and look at training, but also informal group supervisions. Both are really helpful so I can talk through any issues or concerns I have and feel supported to do so." Staff demonstrated good knowledge of their role and had the necessary experience required to carry out their role competently. The manager told us they used the in- house mandatory training, but were also working with local organisations to send staff on additional training.

People we spoke with told us they were happy with the food provided at Highfield Care Home. One person told us, "Food is really very good, there is a choice and nothing is too much trouble for the chef." We observed the lunch time meal and saw that a choice of two menus were offered to people. The food portions were generous and the food appeared nutritious and appealing. People who required food to be pureed or softened had this provided, and there was a constant supply of fluids to accompany the meal.

Lunchtime was a social occasion in the day, and people congregated in a pleasantly decorated dining room, and people enjoyed their meal. We observed that people's relatives were welcome at lunchtime and were encouraged to assist people where this was required.

Where people had been assessed as being at risk of poor nutrition they were referred for dietician support and were in receipt of nutritional supplements and fortified meals. People who required assistance during meal times were supported by the care staff or relatives and we saw records to confirm that people received appropriate amounts of

Requires Improvement

# Is the service effective?

food and fluids. Staff were aware of how to manage people's weight loss and demonstrated to us how they routinely monitored this through regular weighing and reviews.

People and their relatives told us they had regular access to health support from outside the home which included professionals such as the GP, optician, dietician, speech and language therapist, physiotherapists and chiropodists. Records showed that medication reviews, chiropodist visits and GP reviews were undertaken when people's health needs changed.

Good

# Is the service caring?

## Our findings

People and relatives we spoke with were very positive about the care they received. Among many positive comments from people we were told, "I am fortunate to be in such a caring and lovely home." A second person said, "From the cook to the manager everybody is so kind and caring and treats all of us with consideration and respect." Relatives told us that people were cared for in a respectful and courteous manner. One relative told us, "[Person] is always looked after sympathetically and gently. Naturally [Person] gets on better with some than others, but the entire staff treat [Person] in the same manner."

We saw that information about local advocacy services had been made available for people who wished to obtain independent advice or guidance. Confidential information about people's health needs and medical histories was held securely and could only be accessed by authorised staff.

We continuously saw throughout our inspection that staff cared for people sensitively and in a dignified manner. We observed one person in the conservatory who appeared agitated and restless. They were unable to mobilise themselves, however one passing carer noticed this and stopped to assist the person. They sensitively approached this person and asked them if they could help them. Very quietly they moved them from the communal area and helped them with their continence needs, before this compromised the person's dignity. This person later told us, "There's always someone to call on, when I needed help this morning the carer just seemed to know, and asked me very quietly about needing the loo."

Staff understood the importance of people's privacy. We saw staff members knocking on people's doors and waiting to be asked to enter. Staff told us that they would close people's doors when providing personal care and explain what they were doing and respect the person's choices. Relatives told us that there were no restrictions on visiting and that they were always made welcome at the home. They told us that staff encouraged them to assist with mealtimes to promote a sociable atmosphere in the home. The manager told us how family parties were held in the home to cater for special events such as birthdays or Christmas.

We continued to observe throughout the day that both nursing and care staff diligently and positively supported when required. It was clear through our observations that staff were exceptionally busy, however, when care was provided to people it was done by staff who knew people well.

People and relatives told us they felt involved in the day to day decisions made about their care and support needs. We received comments such as, "I feel as involved and I can be," and a second person told us, "I have a say, and it is the final say in what either happens to me or what I do." When we reviewed people's care records we were able to see that discussions had been held with people, and where appropriate, their relatives about their care needs.

Staff told us that at the commencement of each shift they discussed people's needs and whether there had been any changes. We observed one handover and saw staff updating each other about new admissions to the home and their changing care needs. All of the staff we spoke with were able to tell us succinctly about people's current care needs and daily routines. When we spoke with people about their individual needs we found that these matched the staff members. This meant that care was provided to people by staff who knew their individual needs well.

Throughout the inspection we observed staff continuously involve people in discussions about their care. For example, we saw one staff member assist one person with their meal and saw they ensured the person was happy with their choice. They supported the person to eat, and constantly checked to see they were satisfied and comfortable. Prior to leaving the person to assist another they asked if there was anything else they needed and immediately supported this person when they asked for help with the toilet. When the person later returned they were visibly calm and relaxed.

Good

# Is the service responsive?

## Our findings

People told us that they had been involved in planning their own care and staff members were responsive to their needs. Relatives told us that they were involved with developing people's care plans where they were not able to do this themselves and that staff always consulted with them regarding any decisions relating to people's lives. People and their relatives also told us they received good care and support. One person said, "I am really confident that they look after [relative] so well, it is a great comfort to me and all the family."

We saw from care records that people's views and preferences were noted and recorded. For example, people's preferences had been noted for areas such as choice of food, gender of carer, morning and night time routine, where people spent their day and how they liked to receive their personal care. One person told us, "As much as is possible the staff try to get things done just how I like it, and 99.9% of the time they get it right."

Activity staff had developed individual life histories of people, and noted their hobbies, interests and preferences. These were regularly reviewed with the person and developed the individual activity care plan. These were completed between the person and the activity coordinator, and we able to observe a pleasant and friendly exchange of views whilst one of the plans were reviewed. People told us there were a wide variety of activities available in the home and were very complimentary about the activities coordinator. People were encouraged to leave the home for a range of social activities. For example, people had gone on trips to a local garden centre, shopping and attended faith based activities. One group of residents had a weekly coffee meeting in the local town that staff supported them to attend. One person told us, "There's always someone or something to bring a smile to my face each day when I feel a bit lonely or bored."

However, individual activities were not always provided to people who were confined to their bed. Particularly on the upper floor we observed people lying in bed with no radio, television or reading material provided who appeared bored and sad. We spoke with one of these people who told us, "I get the care I need, but I would like staff to spend a little more time with me doing a cross word or listening to some music." A second person told us, "its hit and miss depending on which staff are working. Sometimes they will come in a sit down for a while, other times they don't and I can't do much for myself now. I don't want to go downstairs for baking or sewing, but would like them to stop by and watch the television with me now and then." One person's relative told us, "The activity staff do an amazing job but they need some more, as it's not so easy for the ones who can't get up. What they need is more staff helping people carry on their interests."

We spoke with the manager and regional manager. They agreed that people isolated within their rooms had not always been provided with meaningful activity. During our inspection the regional manager authorised an immediate increase in staffing hours for activity provision. The manager also increased the hours of activity provision so that once activity staff have left for the day, care staff are able to continue to provide activities. They also implemented a plan of activities for the weekends also to help those without visitors to not feel isolated.

People and their relatives told us they felt they could approach both staff and the management team if they were unhappy with the any aspect of the service. One person told us, "It's not a problem to talk to them about things I'm not happy with, in fact I regularly do." Where people had made a complaint these were recorded and reported to the manager for further investigation. The outcome of these investigations was noted, and where necessary reviewed with the regional manager. We saw that a complaints policy was made freely available to people, relatives and visitors to Highfield Care Home and this also signposted people to external organisations for support.

Good

# Is the service well-led?

## Our findings

People, relatives and staff told us they felt the management team was approachable, supportive and listened to their views and opinions. They told us that the manager led by example and felt the environment in the home was open and supportive.

The home had a registered manager in post since September 2014, and events that happened in or that affect the service had been reported to CQC as required. The manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken. This meant that the registration requirements, including the submission of notifications were met.

People and their relatives told us that there were meetings held to keep them informed of events in the home and that these had increased in frequency recently. One person told us, "The manager is always willing to give things we say a go, and feeds back to us what they think is working or not." A second person told us, "[Activity staff] will go around and hand out the minutes from the last meeting, and for those who can't attend, they will ask them if there is anything they want brought up."

We saw that quality audits were routinely undertaken for all aspects of the service. For example, we saw that bed rail audits, mealtime audit, HR audits, medication audits, care plans and an audit of the environment had recently been undertaken. Where shortfalls had been identified, the manager had developed an action plan which they reviewed weekly and discussed with the regional manager on a monthly basis. However, from recently completed care record audits, one completed by the regional manager in December 2014, we noted that issues relating to the completion of MCA and DoLS assessments had not been identified. Where this was completed swiftly after our inspection it had not been identified through the monitoring systems. The manager also used a dependency tool, and assessed falls and accidents to monitor their staffing levels. The manager had identified the need for further staffing and was in the process of recruiting clinical and care staff.

People's care records however had not always been completed in a legible manner where we were able to understand clearly what had been noted. Staff we spoke with were aware of people's current care needs, and told us they were kept informed by daily handover discussions of people's needs. In some cases it was difficult to read the entry made by staff that related to a person's care needs or how their care had been reviewed. For example, one entry noted, "[Person] to be nursed in bed." However it was not recorded how this person had improved or deteriorated. This meant there was a risk that staff new to the home or visiting professionals would not have been able to clearly interpret what people's care needs were.

Staff we spoke with told us that the care records in use were cumbersome and repetitive. One staff member told us, "We have all complained about the size of the care plans, and the manager is bringing in a new one. Sometimes we have to rush to complete the old ones so we're happy to have a simpler one. The managers want the care plans to be robust and manageable which will hopefully make it easier for us to spend more time with the residents." This meant that staff were not always available to assist people in a timely manner as they were distracted by lengthy record keeping. One senior member of staff told us, "Myself and the deputy have been reviewing people's records making sure they are current, based on need and are legible." We were able to see that this was an area that had already been identified by the management team and was in the process of being completed. People's records that we looked at had been reviewed, were much clearer and written in a legible manner. Staff, people and relatives told us they were confident that the management team had acknowledged areas of concern in the home and were positively working to rectify the issues.