Mrs Susan Burns and Mrs Marion Burns

Highfield House Residential Home

Inspection report

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Date of inspection visit:
27 July 2016
28 July 2016
02 August 2016

Date of publication:
10 October 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Highfield House Residential Home is registered with the Care Quality Commission (CQC) to provide personal care and accommodation for up to 25 people. The home is a detached, two storey, converted house set in its own grounds in a quiet residential area of Haswell, County Durham. On the first day of our inspection there were 9 people using the service, although this varied slightly during the inspection. The home comprised of 20 bedrooms on the ground floor and 5 bedrooms on the first floor. 10 bedrooms were en-suite. We saw that the accommodation included two lounges, a dining room, two bathrooms, a shower room, several communal toilets, a conservatory and an enclosed garden.

This inspection took place on 27, 28 July and 2 August 2016 and was unannounced. This meant the staff and the registered provider did not know we would be visiting.
At our last inspection of Highfield House Residential Home on 14, 19 and 27 January 2016 we reported that the registered providers had not made consistent improvements following previous inspections. The registered providers were in breach of the following:
Regulation 12 Safe care and treatment
Regulation 15 Premises and equipment
Regulation 17 Good governance
Regulation 18 Staffing

The overall rating for this service was 'Inadequate' and the service was placed in 'Special measures'. This is where services are kept under review by CQC and if immediate action has not been taken to propose to cancel the registered provider's registration of the service, the location will be inspected again within six months. The expectation is that registered providers found to have been providing inadequate care should have made significant improvements within this timeframe.

At this inspection we found significant improvements had not been made to meet these requirements and Highfield House Residential Home was inadequate in four of the five areas we inspected.

The home was not well run, operational procedures were disorganised and oversight by the registered providers was ineffective.

We found no evidence that a systematic approach to resolve previously identified regulatory requirements was now in place. The registered providers did not ensure that effective action had taken place following a CQC inspection in January 2016 and people using the service were found to be at risk, despite the home being placed in 'Special Measures' and enforcement actions taking place.

The registered providers did not act in a timely fashion to achieve compliance, meet service users' needs and adequately protect them from receiving poor care.

We found that the registered providers did not operate effective systems and processes to assess and

monitor the quality and safety of the services provided

Management monitoring of the home had failed to identify serious shortcomings in the quality and safety of services provided.

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. The manager had been registered with CQC since 26 August 2014. The homes statement of purpose stated that the registered manager was undertaking an undergraduate degree in care home management. However we did not find any evidence of the impact of this training in the management systems at the home.

Also the registered manager and registered providers who were undertaking the leadership role at the home did not demonstrate competent skills and knowledge were held in the areas that the home purports to specialise for example care of people with Dementia type illness.

There was no indication that there was any organised management process for decision making and effective communication of basic tasks involved in the running of the home was not in place.

Medication administration procedures and systems were not robust and did not protect people living at the home from risk associated with poor medicines management. Medicines that have a sedative effect were found to be used without guidance or sufficient agreed practice to safeguard and protect people living at the home.

We found arrangements for safe food production did not protect the health and wellbeing of people living at the home.

People at the home were at increased risk of harm because the registered providers had failed to make adequate plans to be used in the event of a fire and equipment was adequately maintained which increased the risk of a fire taking place.

We found the hot water delivery systems at the home did not protect people living there from injury from water that was too hot. During our inspection the registered providers put in place contingency arrangements to keep people safe.

We found arrangements to ensure control of infections at the home were not robust. Service users and staff at the home were not protected from the risk of water borne infections such as Legionella and actions to detect, prevent and control the spread of infections had not been completed. This showed that people living at the home were not protected from risks from their environment and arrangements to reduce these risks had not been taken.

This showed that people working and living at the home were exposed to unnecessary risk because the registered providers did not ensure that chemical products were used safely.

The registered providers had failed to ensure that some people's dietary requirements were accurate before making substantial changes to their diet posing significant risks to people's health and well-being.

We found that the physical environment throughout the home did not reflect best practice in dementia care. The provider had not considered best practice in the design and use of other areas of the home such as the kitchen

The registered providers and registered manager did not have sufficient understanding of the Mental Capacity Act 2005 (MCA) to ensure people's rights were protected.

People who were living at the home were not being supported by staff who had been trained in their conditions. People may not always be protected from the risks of abuse because staff training in safeguarding was not up to date.

None of the staff or the registered manager had been trained in medicines management sufficient to update them on None of the staff or the registered manager had been trained in medicines management to update them in line with current NICE guidance, 'Managing medicines in care homes.'

The staff took an interest in people and their relatives to provide individual personal care. However people were not always treated with dignity, their privacy was not always protected and the registered provider did not show respect for peoples personal possessions.

Arrangements to ensure timely care planning with other services did not take place and did not ensure the health safety and welfare of service users was promoted when they transferred to other services.

The registered provider had not taken steps to assess, monitor and mitigate the risks relating to the health, safety and welfare of people at the home.

We found changes to care planning arrangements had not been made or considered following significant incidents which put people at the home at risk from receiving inappropriate care.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected against the risks associated with the unsafe use and management of medicines.

The reporting and recording of accidents and incidents was inconsistent and trend analysis was incomplete.

People were not protected against the risks associated with fire, infection control and food safety.

Is the service effective?

Inadequate

The service was not effective.

People who were living at the home were not being supported by staff who had been trained in their conditions. People may not always be protected from the risks of abuse because staff training in safeguarding was not up to date.

There was no indication of an awareness or application of best care practice at the home.

Arrangements to meet the nutritional and hydration needs of service users was not effective.

The physical environment throughout the home did not reflect best practice in dementia care.

Is the service caring?

Requires Improvement

The service was not always caring.

The staff took an interest in people and their relatives to provide individual personal care. They demonstrated a knowledge of people's personal histories and their likes and dislikes.

People were not always treated with dignity and their privacy

was not always protected.

The registered provider did not show respect for people's personal possessions.

Is the service responsive?

Inadequate

The service was not responsive.

There were significant omissions in people's care planning arrangements which placed them at risk.

People were being administered with sedative medications without a detailed care plan being in place or any justification for doing so.

Arrangements were not in place at the home to ensure that transition between services can take place effectively and safely.

Is the service well-led?

Inadequate

The service was not well-led.

Arrangements to ensure the home improved following previous inspections and subsequent actions by CQC had been ineffective.

There was no clear leadership or accountability within the service.

The quality assurance systems in place were not effective to assess, monitor and drive improvement in the quality and the safety of the service provided.

Highfield House Residential 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 registered providers were meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27, 28 July and 2 August 2016 and was unannounced. This meant the staff and the registered provider did not know we would be visiting. The inspection was carried out by two adult social care inspectors and a specialist pharmacy inspector.

Before we visited the home we checked the information we held about this location and the registered providers, for example, inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service, including commissioners, safeguarding and infection control staff. Ongoing monitoring of the service was taking place by service commissioners in order to check if the service improved in line with their contractual agreements.

During our inspection we spoke with five people who used the service and one relative. We spoke with two visiting district nurses and one visiting social worker. We looked at the personal care records of nine people who used the service and observed how people were being cared for.

We spoke with the registered manager, the two registered providers, three care staff and one housekeeping staff. We reviewed care planning records, staff training supervision records and looked at other records relating to the management of the service such as audits, policies and risk assessments.

Prior to this inspection we did not ask the providers to complete a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used information given by the provider from other sources to inform

our inspection.

Inadequate

Is the service safe?

Our findings

People who used the service told us they felt safe in the home. A relative told us, "My [relative] is well looked after, they keep [their relative] safe and the staff work very hard."

A member of staff told us, "It's much safer than the last time you [CQC inspectors] were here; They've tidied up and chucked a lot of rubbish out and we've had fire drills."

At our previous inspection in January 2016 we identified that medication practices at the home did not ensure peoples' safety. Medication administration procedures and systems were not robust and did not protect people living at the home from risk associated with poor medicines management.

Records relating to medication were not completed correctly placing people at risk of medication errors. Medicines stock balance did not match. Medicine stocks were not properly recorded when medicines were received into the home or when medicines stocks were carried forward from the previous month. For medicines with a choice of dose, the records did not always show how much medicine the person had been given by staff at each dose. Management oversight (audits) did not include a check of stock held against the records to see if these were accurate and determine if appropriate administration had taken place.

In the registered provider's policy we found guidance was to be given to staff on the application of topical medicines (creams) which stated, 'Care plans should be in place for application of the topical medicines including where to apply the cream, the frequency and the amount to be applied'. However we saw these were incomplete and the recording of the application of these treatments was poor. These did not direct about where to apply creams where multiple treatments were made and some records had information that did not match application. We also found some creams were still being stored in people's bedrooms and had no date of opening noted so their continued effectiveness could not be ascertained.

We found some people were prescribed rescue medications where people had conditions which required urgent administration of prescribed treatment by staff. However there were no instructions or care plan in place which would indicate when rescue medications should be administered and guide staff practice. CQC made a vulnerable adults safeguarding alert to the local authority in order to ensure service users were protected at the home. At the conclusion of our inspection the registered manager had sought medical advice and updated the relevant care plan.

We found the registered providers had a medicines policy in place. The policy stated that it should be read in conjunction with the Royal Pharmaceutical Guidance – Handling Medicines in Social Care (2008) which took precedence over the policy. However further updated guidance published in March 2014 was issued by the National Institute for Health and Care Excellence [NICE] entitled 'Managing medicines in care homes'. We found the registered providers were not following the latest guidance in medicines management.

We found medicines that have a sedative effect were found to be used without guidance or sufficient agreed practice to safeguard and protect people living at the home. For example, we did not find evidence of

actions staff should take to prevent or help people from becoming agitated or descriptions of any triggers, thresholds where medication should / should not be given or alternative techniques / strategies. There was no limit to the amount of sedation which could be given so people were at risk of over sedation. We found records which showed that people had received sedation medicines without any justification for their use. Guidance issued by professional and expert bodies such as the National Institute for Care Excellence (NICE) guidance 'Dementia Supporting service users with dementia and their carers in health and social care' 2006 was not in place at the home. This provides guidance on the prescribing of medicines for people with dementia type conditions. The registered manager and providers agreed these were not in place. The registered manager questioned why these arrangements were required and sought detailed advice from inspectors. CQC made a vulnerable adults safeguarding alert to the local authority in order to ensure service users were protected at the home. At the conclusion of our inspection the registered manager had sought medical advice and updated the relevant care plan.

We found arrangements for the safe food production did not protect the health and wellbeing of people living at the home. Food production records were not routinely kept. Inspectors found only two records being kept of all food production. This consisted of the name of the meal produced (only) and the refrigerator / freezer temperatures at the beginning and end of each day up until 25/07/16. There were no records for the 2 days prior to the CQC inspection on 27 July 2016. However we found that accurate recording of food storage temperatures of food in the refrigerator was not in place. Records listed the temperature as being consistently at 8 degrees twice each day for several months. This is too warm (too high for safe refrigeration). When asked, the registered provider located the thermometer at the back of the fridge where it was reading eighteen degrees. The provider suggested it was broken. The thermometer was a catering type which showed the temperature should be no more than five degrees. Inspectors found 'open' foods in the refrigerator including mayonnaise, defrosted food (meats) or food produced by the home (e.g. sandwiches). These were not labelled to indicate shelf life, opening times or manufacturing date. There appeared to be no order to the food storage in the refrigerator. There were no arrangements in place for the safe defrosting of foodstuffs, there was no separation of the kitchen for use with cooked or uncooked foods and whilst there was equipment to check the temperature of cooked foods, these were not routinely recorded. There were no records which detailed arrangements for managing ingredients likely to cause allergic responses. The arrangements for food production follow published guidance such as 'Safer Food Better Business' or Health and Safety Executive Guidance "Health and Safety in Care Homes". We found the home had the 'Safer Food Better Business" guidance but had not followed the guidance. This placed people living and working at the home at risk of receiving food that was not safely produced.

This was breach of Regulation 12 of The Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We found that there was no overall evacuation plan which would clearly inform staff about the steps they should take to help safeguard themselves and people living at the home in the event of a fire. There was no information to direct the lead person and staff as to the appropriate measures they should take should a fire occur which took account of the design and layout of the home. The signs around the home to direct people in the event of a fire were contradictory. For example the sign in the dining area directed people away from a designated fire exit one metre away and through two rooms into the garden. The home did have personal emergency evacuation plans (PEEPs)for people living there but this contradicted the signage in their bedrooms and (different) signage in communal rooms. The PEEPs required staff to take people out of their individual bedrooms into the garden and up stone steps to the car park at the front of the house. Following this route we found combustible materials such as rubbish, old mattresses, furniture, soft furnishings etc. adjacent to the escape route from the garden which could significantly compromise peoples' safety in the event of a fire. There was no evidence that the home had sought or implemented guidance such as HM

Government Guide to Fire Safety Risk Assessment: Residential Care Premises. Compiled by National Association for Safety and Health in Care Services (NASHiCS) and the Chief Fire Officers Association (CFOA) Business Safety Group. This showed that people at the home were at increased risk of harm because the registered providers had failed to make adequate plans to be used in the event of a fire.

We also found that the homes clothes dryer displayed signs of overheating. The flock collection tray was distorted allowing flock to escape down each side. We found significant flock build up in the extractor vent duct outside. There was no evidence that the outlet had been routinely cleaned nor that flock has been removed from the remaining duct. The registered provider did not have evidence that showed regular maintenance or cleaning had taken place or was planned. CQC contacted the County Durham and Darlington Fire and Rescue Service to advise of our findings. This showed that people at the home were at increased risk of harm because the provider had failed to make sure that equipment was adequately maintained.

An Initial Inspection Feedback Summary Form was completed on 28 July 2016 to draw these issues to the attention of the registered manager and registered providers.

We found the hot water delivery systems at the home did not protect people living there from injury. We found one bathroom which was available for people to use delivered hot water which was too hot to touch. There was no thermometer present in this bathroom. At our request, a thermometer was provided however a considerable build-up of scum / debris was noted. We measured the temperature of the water which indicated 48 degrees centigrade [which was too hot for bathing] and requested an alternative however there was only one thermometer available. There were no other records to indicate that the thermometer was accurate. Records showed that the bath water temperature was not routinely checked. The registered providers and registered manager agreed the water was too hot. Hot water temperature checks had been carried out and were not within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014. This placed service users at risk of serious injury through immersion in water that was too hot. The registered providers closed down the hot water systems to the area of the home where we had raised our concern and advised us they had called a plumber.

An initial Inspection Feedback Summary Form was completed on 28 July 2016 to record our concerns and draw this to the attention of the registered manager and registered providers.

We found arrangements to ensure control of infections at the home were not robust. For example we found that mops were being washed in a plastic bowl in the laundry sink despite there being facilities for the hygienic washing of cleaning mops using the homes industrial washing machine,. The sink was also designated as a hand washing site and should have been protected to prevent cross contamination. The home also did not have facilities for the effective cleaning of floor surfaces such as carpets in the event of a spillage or soiling. We noted that some of the homes carpets were in need of cleaning and odour control in bedrooms was not always effective.

We saw no evidence to show that guidance from the Health and Safety Executive's publication 'Health and Safety in Care Homes' in relation to the spread of water borne infections such as Legionella had been considered at the home. The registered providers had in place a risk assessment which showed risks were managed through weekly water testing. During the course of the inspection we asked the provider for the latest record of checks relating to the fitness of the water delivery and storage systems at the home and evidence of the steps taken to reduce the risk to service users and staff. However arrangements to minimise the risk of water borne infections (Legionella) could not be determined by the registered providers or registered manager. Procedures at the home indicated that checks were to take place every 12 months but

records of this could not be produced by the registered providers or registered manager. In addition there were 15 rooms in the building which were not used but had sinks and or bathrooms in place which could present an increased infection risk. We found that service users and staff at the home were not protected from the risk of water borne infections such as Legionella and actions to detect, prevent and control the spread of infections had not been completed.

When we visited the home we found that none of the freestanding wardrobes in people's bedrooms were secured to help prevent injury to people living at the home should they accidentally fall over whilst in use. We explained these concerns to the registered provider(s) and registered manager and issued an Initial Inspection Feedback Summary to bring this to the attention of the registered providers and registered manager. We also sought other written confirmation that wardrobes had been secured from the registered providers. This showed that people living at the home were not protected from risks from their environment and arrangements to reduce these risks had not been taken.

This was breach of Regulation 15 [Premises and Equipment] of The Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We looked at the arrangements put in place at the home to ensure that chemicals used in the cleaning or maintenance of the home were stored and used safely. We sampled seven chemicals being used at the home including professional type cleaners containing ingredients which were likely to cause injury if accidentally splashed or consumed. We found six of the seven products we checked did not have corresponding suitable information which could be used to promote safe storage and which could be followed in an emergency. We asked the registered manager to show they were compliant with the Control of Substances Hazardous to Health (COSHH) Regulations 2002 (as amended) but they were unable to do so. This showed that people working and living at the home were exposed to unnecessary risk because the provider did not ensure that chemical products were used safely.

We found incidents where people at the home had received accidental injuries were not always reported. We examined accident reports for July and found none had been completed. However we found other records which showed accidents had occurred but had not been reported. We also found that analysis to look at circumstances or trends which could help prevent repeat occurrences had not been undertaken by the registered manager or registered providers. The registered provider confirmed that no accident reports or any subsequent analysis had been completed in July despite accidents taken place. This meant that the registered provider failed to effectively assess, monitor and mitigate the risks related to people's health and safety.

This was breach of Regulation 17 [Good Governance] of The Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

The provider had in place a safeguarding policy which provided staff with guidance regarding how to report any allegations of abuse, protect vulnerable adults from abuse and how to address incidents of abuse. Staff we spoke with told us they felt confident in reporting any concerns they had. However we found that staff training in safeguarding was not up to date. This meant that people may not always be protected from the risks of abuse.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

A visiting professional told us, "The provider is always helpful and the staff all seem to go out of their way to help us when we come here."

We looked at care planning and other records to see how the registered providers took account of people's dietary needs. Since the last inspection the weighing scales had been recalibrated and checked to make sure they were accurate and people's weights were being monitored.

We found there were people living at the home who had specific dietary needs and required a particular diet to support their health and well-being. These included dietary needs to support Diabetes or Chronic Obstructive Pulmonary Disease (COPD). There was also no evidence that published guidance such as that from the National Institute for Health and Care Excellence (NICE) entitled 'Chronic obstructive pulmonary disease in over 16s: diagnosis and management: NICE guidelines [CG101]' [published date: June 2010], had been considered or put in place at the home. There was no record of any specialist meals that had been produced which had taken their needs into consideration. There was no evidence of how potential dietary allergens had been considered for example nuts / gluten. We did not find evidence that guidance such as that produced by the National Institute for Health and Care Excellence (NICE) entitled 'Nutrition support in adults' (NICE clinical guideline 32) had been used at the home. The registered providers had also failed to ensure that some people's dietary requirements were accurate before making substantial changes to their diet. This course of action posed significant risks to people's health and well-being.

This was breach of Regulation 14 [Meeting nutritional and hydration needs] of The Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

When we visited we found that the home had a commercial type kitchen including two catering type ovens and an oil fryer. Meals were being produced at the home, however we noted that there was not an extractor to remove heat cooking smells a lack of extraction and the smell and heat was instead dissipated into the lounge and dining areas of the home. The registered providers told us that this arrangement had been in place for a number of years. We found that published guidance such as that produced by the Health and Safety Executive entitled 'Ventilation of kitchens in catering establishments' had not been considered. This showed that the registered providers had not considered best practice in the design and use of premises.

Since our last visit we found improvements had been carried out and the home had been de-cluttered. Rooms had been cleared out and were no longer used as storage facilities. One of the providers told us they no longer used one of the rooms as a smoking room.

We found that the physical environment throughout the home did not reflect best practice in dementia care. The National Institute for Health and Care Excellence [NICE], guidelines 'Dementia: Supporting people with dementia and their carers in health and social care 2006' states, 'Built environments should be enabling and aid orientation. Specific, but not exclusive, attention should be paid to: lighting, colour schemes, floor coverings, assistive technology, signage, garden design, and the access to and safety of the external

environment'.

During the inspection we spent time in the home where people with dementia type illnesses were accommodated. We found the provider had made some improvements by putting pictures of toilets and shower rooms placed on doors and blue light pull cords in some toilets. There was no further evidence of adaptations to the environment to show good practice guidelines had been put into practice. For example, there was no evidence of contrasting colours being used to aid independence, for instance on light switches, grab rails and bathroom / bedroom doors. Corridors were all similar in colour and the lighting in the corridors was poor. We asked the registered manager what model of dementia care the registered providers adopted, for example social, psychological, or a person centred approach to dementia care. She confirmed that no specific model of dementia care had been used in the care home to guide and inform best practice. This demonstrated that the registered providers had failed to follow good practice guidelines issued by NICE, the non-departmental public body with the responsibility to develop guidance and set quality standards for social care.

This was breach of Regulation 15 [Premises and Equipment] of The Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS].

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found in care plans that records of assessments of capacity had taken place. Applications for DoLS had been submitted by the registered providers since the last inspection in relation to some people residing at the home. However we found that for some people, restrictions had been put in place to prevent them from leaving the home despite them having an assessment which showed they had mental capacity to make decisions in their own best interests. There is no information or guidance in care plans to indicate when it was appropriate or inappropriate to deprive people of their liberty. This demonstrated that the registered providers and registered manager did not have sufficient understanding of the MCA to ensure people's rights were protected.

We looked at the way staff were supported to gain the skills and knowledge they needed to support the needs of people living at the home. We were advised by the registered manager that a training matrix was in the process of being devised. We reviewed this document which was incomplete, and was hand drawn on the back of a child's educational poster. We found that staff training records had not been compiled which would demonstrate the level of staff training overall or how this supported the services aims or peoples' needs. We also looked at six staff files and found these contained very little information about training. We saw since our last inspection some staff had begun training in food safety, health and safety and had completed training in the use of fire extinguishers. There was no information to confirm they had the competency to meet the mental health needs of the people who displayed behaviours that challenge; needs of people with a dementia type illness; or peoples' physical health needs. We found that people at the home were cared for by staff who were not trained in their condition or were knowledgeable about current best practice. For example COPD, Dementia, Diabetes or behaviours which challenge staff. None of the staff or

the registered manager had been trained in medicines management to update them on current Royal Pharmaceutical Society Guidance for the storage and administration of medicines in care homes.

There was no indication or evidence that either the registered manager or registered providers [who were working in various management, care and catering capacities at the home] had appropriate training to suitable to carry out these roles.

We observed the registered providers preparing people's meals in the kitchen. One of the providers confirmed they were employed in producing food at the home assisted by senior care staff when required. No catering training records were found for either of the providers or the registered manager. Food hygiene certificates for the provider partners had been altered to look like training had been accomplished. We wrote to the registered providers to obtain evidence that accredited food hygiene training had taken place for all staff delivering food.

This is a breach of regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] 2014.

Staff told us they had received supervision from their manager. We found staff supervision records were in place to confirm this.

Requires Improvement

Is the service caring?

Our findings

People who used the service and their relatives were complimentary about the care at Highfield House Residential Home. They told us they were happy with the care they received. One relative told us, "The care from the staff is very good; I wouldn't want my [relative] to be anywhere else." People told us they were, 'All right' and would 'get anything they liked.' A visiting professional told us, "They [the staff] always seem like they're getting on really well with people and they really care – they have a good rapport."

We saw staff had helped people to remain well presented and they looked comfortable. We saw staff talking to people in a polite and respectful manner. We observed staff supporting people to transfer from a chair in the lounge to their wheelchair. They spoke in encouraging tones, advising people what to do next and allowed the people to move at their own pace.

We found the registered providers had maintained personal records for one person which were stored on the hand rail outside of bedrooms. This meant that any staff member service user or visitor walking in the corridor could pick up and read highly personal information. This did not protect their privacy or dignity.

We saw the bedrooms were individualised, some with people's own furniture and personal possessions. We saw many photographs of relatives and occasions in people's bedrooms. However when we examined some people's records relating to their possessions at the home we found that they were listed as 'All Possessions', 'All photographs' and 'All clothing.' The actual items were not listed and could not be identified at the home. A property checklist is used to record each person's possessions throughout their stay at the home and helps ensure these remain safe. Recording people's personal possessions in this way did not demonstrate that they or their belongings were valued by the registered providers or that they were treated with dignity and respect.

This is a breach of Regulation 10 [Dignity and Respect] of the Health and Social Care Act 2008 [Regulated Activities] 2014.

We saw staff interacted with people for example encouraging them to engage in conversation or asking people if they wanted help when they passed them in the lounges or in their bedrooms. We observed one member of staff engage a person to discuss one of their outings using photographs on a lap top. The person spoke to us about their day and how they had enjoyed it.

All the people we spoke with told us they could have visitors whenever they wished. The relative we spoke with told us they could visit at any time and were always made welcome.

Information for people and their relatives was displayed on notice boards throughout the home including, for example, safeguarding, advocacy, Alzheimer's disease and complaints. This meant the home was giving people access to relevant information about their care needs.

Staff were able to give us information about people including their likes and dislikes and information about

their backgrounds. We observed people were comfortable in the presence of staff.

During our inspection there was no one in the home who had an advocate. Staff were able to tell us about people's relatives and how they were involved in their care. We saw family members had been contacted and kept informed about their relative, for example when they needed to go to hospital.

At our last inspection we noted people's records were not stored confidentially. During this inspection we saw the office area of the home had been improved and people's records were now stored behind a locked door. This meant confidentiality had improved.

Inadequate

Is the service responsive?

Our findings

When we visited the home we looked at individual's records to see how their care was planned, monitored and co-ordinated.

We spoke with the registered providers who told us every person who lived at Highfield House Residential Home now had a care plan. They told us that the information about people's needs had now been combined into one care plan file which contained all of the presently held information about each person's needs. We looked at nine peoples' care plans in detail. We saw an assessment of each person's needs had been carried out by the registered manager or registered providers or the person's social worker / care manager.

People were being administered with sedative medications without a detailed care plan being in place or any justification for doing so. There was no avoidance strategies recorded, likely triggers to agitation, alternative strategies or thresholds where medication should / should not be given. There was no professional guidance in place and staff had not been trained in how to support people with these needs. This showed that care and treatment for people at the home was not provided in a way which ensured their safety. We drew this to the attention of the registered manager who commenced completion of care plans.

CQC made vulnerable adults safeguarding alerts to the local authority in order to ensure people living in the home were protected.

We looked at the arrangements in place at the home to ensure that transition between services can take place effectively and safely. This is particularly important where people may need to transfer to hospital or clinical services at short notice in response to a sudden onset of illness. We found that people at the home had required emergency medical treatment but the registered providers had failed to produce a procedure or useful documents which informed either attending paramedic personnel or hospital clinicians about service user's known / long term conditions and present treatments. This meant that arrangements to ensure timely care planning with other services did not take place and did not ensure the health, safety and welfare of service users was promoted.

This was breach of Regulation 12 [Safe care and treatment] of The Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

There were shortfalls in significant parts of some people's care plans, in particular where they had complex or risky complicating needs. For example, where people had significant medical conditions such as COPD or Diabetes, there was not a care plan in place which described how these needs were to be met at the home and guide staff practice. There was also no assessment to show that risks had been considered and risk reduction measures / procedures identified.
There were no plans which recognised other contributory factors for example dietary considerations. This meant that the registered providers had no plans in place which could be used by staff to monitor people's condition, recognise any deterioration and take appropriate action. There was no guidance or symptom

descriptions to advise staff of actions to take in an emergency such as administering urgent medications. We found people had required urgent medical care in hospital without first having the emergency treatments which had been prescribed for staff to use at the home in these circumstances. This showed that the registered providers had not taken steps to assess, monitor and mitigate the risks relating to the health, safety and welfare of people living at the home. We drew this to the attention of the registered manager who completed the care plans for the areas we had identified.

CQC made vulnerable adults safeguarding alerts to the local authority in order to ensure service users were protected at the home.

We found changes or updates were not made to care plans or risk assessments following significant incidents. We found examples of where people had collapsed or fallen at the home resulting in a medical investigation by other agencies. We found follow up appointments at the home had been carried out by physiotherapy staff from the National Health Service [NHS] 'Falls and Osteoporosis clinic'. However these were not recorded accurately in people's care plans. In addition no changes were made to care plans or risk assessments. We found changes to care planning arrangements had not been made or considered following significant incidents which put people at the home at risk.

We looked at the arrangements put in place at the home to support people who had or were likely to sustain skin pressure damage. The service had used a 'Waterlow' assessment to determine peoples' needs where they were at increased risk due to their deterioration or mobility issues. However we found for some people the assessment did not match the equipment / risk reduction measure that had been put in place. For example assessments which indicated that people required 'alternating pressure overlay, mattress and bed systems' in the scoring system were actually using 'overlays or specialist foam mattress' which is a lower risk. We asked the registered providers to explain why the different equipment had been used when the assessment clearly indicated which level of aid should have been used. They were unable to give an explanation and offered to change the assessment to match the equipment being used. This showed the providers did not take appropriate steps to assess, monitor and mitigate the risks relating to the health safety and welfare of people at the home.

This was breach of Regulation 17 [Good Governance] of The Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We checked complaints records. This showed that procedures were in place and could be followed if complaints were made. The complaints policy was seen on file. The policy provided people who used the service and their representatives with information about how to raise any concerns and how they would be managed. The relatives we spoke with were aware of the complaints process. There had been no complaints recorded since our inspection of June 2015.

We looked at activities in the home and found staff engaged people in meaningful conversations about their day. One staff member worked additional hours to provide activities. We observed people getting involved in action songs followed by singing hymns. One person was reading a daily newspaper and another person was engaged at looking at photographs.

Inadequate

Is the service well-led?

Our findings

The home was not well run, operational procedures were disorganised and oversight by the registered providers who also worked in the service and the registered manager was ineffective.

We found no evidence that a systematic approach to resolve previously identified regulatory requirements was now in place. At the previous inspection of January 2016 we identified serious concerns with the standards of care provided at Highfield House Residential Home including breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included: Safe care and treatment; Premises and Equipment; Good governance; Staffing.

At this inspection we found that the registered providers failed to make improvements to the quality and safety of services for people at the home. The registered providers did not ensure that effective action had taken place following a CQC inspection in January 2016 where the home was found to be in breach of four regulations and people using the service were found to be at risk, despite the home being placed in 'Special measures' and enforcement actions taking place. The registered provider did not act in a timely fashion to achieve compliance, meet service users' needs and adequately protect them from receiving poor care.

We found that the registered providers did not operate effective systems and processes to assess and monitor the quality and safety of the services provided. We looked at what the registered manager and providers did to check the quality of the service. There was evidence that audits had been carried out for key areas at the home such as fire safety, care planning, medication and water temperature management. However these had failed to identify serious gaps which could place people at the home at increased risk or effect their health and well-being.
Management monitoring of the home had failed to identify serious shortcomings in the quality and safety of services provided including for example; lack of care plans for people with complicating medical conditions; inadequate and contradictory fire safety arrangements; poor / unsafe medicines management and practices; dangerous hot water management and clothes dryer fire risks; poor infection control arrangements; poor control of substances hazardous to health (COSHH); lack of safe food production; poor accidents / incidents recording and analysis. This meant that the service did not effectively assess, monitor and improve the quality and safety of the services provided.

We found the registered providers were working in several capacities such as care and catering roles at the home. However we could not identify that suitable training such as basic or advanced food hygiene or training in areas pertinent to the needs of people at the home for example dementia type illness. We asked the registered manager for evidence that accredited food safety training had been undertaken and we were shown certificates for both registered providers. However these had been altered so as to look as if training had been achieved. CQC did not accept this evidence and a request for further evidence was ignored by the registered providers.
This showed that the registered providers did not act in an open and transparent manner.

At the end of this inspection CQC remained concerned about several areas where service users remained at

risk. For example, from freestanding wardrobes in people's rooms which were not secure. CQC wrote to the registered providers to request this information but none was received. This showed that the registered providers did not work in an open and transparent way to ensure the health safety and welfare of service users was upheld.

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. The registered manager had been registered with CQC since 26 August 2014. The homes statement of purpose stated that the manager was undertaking an undergraduate degree in care home management. However we did not find any evidence of the impact of this training in the management systems at the home. Also the registered manager and registered providers who were undertaking the leadership role at the home did not demonstrate that competent skills and knowledge was held in the areas that the home purports to specialise in. This included, supporting people with Dementia type illnesses, associated medical conditions, safe use of medication and sedation. This significantly hampered their ability to support staff activity, skills, knowledge and direction.

There was no indication that there was any organised management process for decision making and effective communication of basic tasks involved in the running of the home was not in place. A framework for making important decisions in relation to the home was unclear and we received contradictory information from both registered providers and the registered manager. This meant that there were no clear leadership or accountability within the service and the governance systems were ineffective.

This was breach of Regulation 17 [Good Governance] of The Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People and their possessions were not always treated with dignity and respect.

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 Care and treatment was not provided in a safe way. Risk assessments were not in place or did not give staff clear guidance on how to ensure risks were mitigated. People's medicines were not managed in a safe way.

The enforcement action we took:

Following relevant enforcement processes, CQC cancelled the providers Registration on 4 October 2016 under Section 17 of the Health and Social Care Act 2008 in respect of the Regulated Activity 'Accommodation for persons who require nursing or personal care.'

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Arrangements to meet the nutritional and hydration needs of service users were not effective.

The enforcement action we took:

Following relevant enforcement processes, CQC cancelled the providers Registration on 4 October 2016 under Section 17 of the Health and Social Care Act 2008 in respect of the Regulated Activity 'Accommodation for persons who require nursing or personal care.'

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered providers did not ensure effective cleaning and infection control was in place at the home. The registered providers did not ensure that the premises were suitable for the purpose for which

they were being used.

The provider did not ensure that equipment was being properly maintained.

The enforcement action we took:

Following relevant enforcement processes, CQC cancelled the providers Registration on 4 October 2016 under Section 17 of the Health and Social Care Act 2008 in respect of the Regulated Activity 'Accommodation for persons who require nursing or personal care.'

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered providers were not operating open effective systems and processes to ensure good governance. The registered providers did not effectively assess, monitor and mitigate the risks related to the health, safety and welfare of people who used the service. Accurate, complete and contemporaneous records in respect of each service user were not being securely maintained. Actions to assess, monitor and mitigate the risks to the health safety and welfare of service users and others we

The enforcement action we took:

Following relevant enforcement processes, CQC cancelled the providers Registration on 4 October 2016 under Section 17 of the Health and Social Care Act 2008 in respect of the Regulated Activity 'Accommodation for persons who require nursing or personal care.'

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff and management working at the home did not have the appropriate skills, training and experience to carry out their duties.

The enforcement action we took:

Following relevant enforcement processes, CQC cancelled the providers Registration on 4 October 2016 under Section 17 of the Health and Social Care Act 2008 in respect of the Regulated Activity 'Accommodation for persons who require nursing or personal care.'