Tamhealth Limited

Highfield Care Home

Inspection report

34 - 36 Hoe Lane
Ware
Hertfordshire
SG12 9NZ

Tel: 01920467508
Website: www.brighterkind.com/highfield

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 19 September 2018 and 08 October 2018. During our last comprehensive inspection on 02 August 2017 we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to keeping people safe, personalised care and support, dignity and governance. We rated the service requires improvement.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the five key questions, Safe, Effective, Caring, Responsive and Well-led to good. At this inspection we found that not all the areas we previously found not meeting the required standards were improved.

Highfield Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Highfield Care Home is a purpose-built care home and is registered to provide accommodation and personal care for up 54 older people some of whom are living with dementia. At the time of our inspection 42 people were living at Highfield Care Home.

There was a recently employed manager in post, however they were not registered at the time of the inspection. 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.

People we spoke with told us they felt safe in the home. Relatives told us they felt that the care people received was safe. However, we observed, during the inspection that staff did not always follow guidance given by health professionals for people who needed assistance with their meals because they were at risk of choking.

Risk assessments had been completed and were regularly reviewed. However, when staff completed risk assessment tools to ascertain the level of risk presented to people the scores were not added up correctly and were not consistently reflected in assessment of need care documents or care plans. This meant that there was a risk people did not have the appropriate measures in place to mitigate the identified risks.

People told us that there were less staff over weekends and on occasions they had to wait long period of times for staff to answer their call bells. This was confirmed by relatives who told us that at the weekends there was always a shortage of staff. Staff members we spoke with told us there were not enough staff deployed to meet people`s needs in a timely way. Our observations confirmed that staff were stretched and busy which led to some people`s support being carried out in a rush.

People told us staff were kind and caring and protected their dignity and privacy. Care plans were developed

and were reflective of people`s likes, dislikes and preferences, however not all care plans we reviewed had been updated following a change in people`s needs. Care plans contained a high level of information that was not helpful for staff and it did not give sufficient guidance in how staff should meet people`s needs in a personalised way.

Where people were identified at risk of malnutrition or dehydration and required their food and fluid intake monitored, this had not been done effectively. Where people used their own mobility equipment risk assessments were not developed and assessments were not carried out by the provider to ensure the equipment was suitable and in good working order as well as used correctly by people.

Safe and effective recruitment practices were followed to ensure that staff working at the home were of good character and suitable for the roles they performed.

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

Staff asked people for their consent before they carried out any care, however mental capacity assessments were not carried out consistently and best interest processes were not always followed. Where people had behaviours which challenged others there were no care plans developed to offer staff guidance on how to manage and prevent these behaviours.

People told us that the activity provision in the home could be improved with more outings and activities which were more suitable to their needs. We observed activities on the day of the inspection and found that people were not interested and motivated to engage with what was on offer.

People told us they would report their concerns to the office but due to recent management changes they did not know the manager or the person in charge to share their worries. Complaints were recorded and responded too, however not always following the providers complaint policy.

People and staff had been invited to regular meetings where they could raise any issues and discuss how they wanted to improve the service. We found that some requests resulted from these meetings were actioned, however there were actions discussed in several meetings were there was no action from the provider to address these.

There were a range of audits carried out by the deputy manager and the provider to look at the quality of the service they provided to people. We found that they identified areas which needed improving, however not all these areas resulted in improvement actions and rolled over from one audit to the other.

Some of the concerns we identified through this inspection had not been identified through the providers quality monitoring systems.

This is the third consecutive time the service has been rated Requires Improvement. You can see what action we told the provider 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?

Requires Improvement

The service was not always safe.

People told us they felt safe, however we observed that at times the care and support people received had not promoted their safety.

People told us on occasion they had to wait a long period of time for their call bells to be answered and mainly over weekends there was a shortage of staff.

Risk assessments were developed following the completion of a risk assessment tool, however scores were not added up correctly and this could have affected the measures put in place to mitigate risks for people.

Risks involved in people using their own electric wheelchairs was not assessed and there were no processes in place for the provider to assure themselves that these were regularly serviced and safe to use in the home.

Staff were knowledgeable about the risks of abuse; however, some staff were not aware of the whistleblowing policy and external safeguarding authorities they could report concerns to.

Recruitment procedures were robust and ensured there were suitable staff working at the home.

Medicines were administered safely by appropriately trained staff. There were infection control procedures in place to prevent the spread of infections.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff told us that the last few months were unsettling for them with all the management changes and they did not feel supported by the provider.

Staff received induction training when they started working, however annual refresher training considered mandatory by the

provider had lapsed for a considerable number of staff.

Mental capacity assessments were carried out to establish if people had capacity to understand and take decisions regarding the care and support they received, however best interest processes were not always followed.

People told us they were happy with the quality of the meals provided.

People had access to health care professionals when there was a need for it.□

Is the service caring?

Requires Improvement

The service was not always caring.

Care was provided in a way that promoted people's dignity and respected their privacy, however some systems used supported institutional practice.

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

People told us they did not know about their care plan and they were not involved in any reviews of their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People`s care plans were detailed about their likes, dislikes and preferences regarding their care, however some systems and daily routine staff followed restricted them to provide personalised care.

People who were more independent were supported to pursue their hobbies and interest however activities for people who needed staff`s support to help them engage were limited.

People`s end of life care needs were assessed.

People and their relatives felt confident to raise concerns with staff.□

Is the service well-led?

Requires Improvement

The service was not always well-led.

A manager was recruited and started at the service a few weeks prior to this inspection, however they were not registered with the Care Quality Commission (CQC).

Quality assurance systems in place were used by the staff and provider to carry out audits, however little improvements were seen since the previous inspection.

There were regular meetings organised for people and staff. Staff found these helpful, however people told us that often they could see no improvement on issues they reported in these meetings.

People, their relatives told us that overall, they were happy with the service, however they did not know who the manager was currently.□

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 unannounced and carried out on 19 September by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of having used a similar service or who has cared for someone who has used this type of care service. On 08 October 2018 we carried out the second day of the inspection to meet the manager who was not in the home on the first day of the inspection.

Before the inspection we reviewed information, we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We reviewed a copy of the action plan that was submitted to us after the previous inspection, and also sought feedback from social care professionals visiting the home regularly. We reviewed the provider information return (PIR) submitted to us. This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make.

During the inspection we spoke with 11 people who lived at the home, four relatives, six staff members, three nurses, the maintenance staff, the deputy manager, a manager from another home owned by the provider and the provider`s regional manager. We also received feedback from the local authority and reviewed the commissioner's report of their most recent inspection.

We looked at care plans relating to seven people and three staff files in addition to records relating to the management of the service.

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

When we inspected Highfield Care Home on 02 August 2017 we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people's health and welfare were not sufficiently mitigated to keep people safe. At this inspection we found that some improvements were made, however further improvements were needed to ensure risks to people`s health and well-being were effectively assessed and mitigated.

Not all the risks involved in people`s daily living were assessed. For example, people who used electric wheelchairs in the home which they operated themselves had no risk assessments in place to assess the risk involved to them or to other people living in the home when this equipment was used. People told us staff had not explained risks to them regarding the use of these wheelchairs and the use of lap belts when they were operating these. The provider had no arrangements in place to assure themselves that these were regularly serviced and safe to use.

Where risk assessments had been completed these were regularly reviewed. However, when staff completed risk assessment tools to ascertain the level of risk presented to people the scores were not added up correctly and were not consistently reflected in assessment of need care documents or relevant care plans. This meant that there was a risk that people did not have the appropriate measures in place to mitigate the identified risks. For example, a person had been assessed by staff using a fall risk assessment tool as being medium risk of falls with a score of 14 although they had regular falls. When we added up the risk scores we found that it was 16 which placed the person at high risk and staff who completed the assessment had made an error. Although the error had been made in May 2018 when updating the monthly care plan staff did not notice this and continued to record that the person was at medium risk of falls. Therefore, there was a risk that the measures in place to mitigate the risk of falls were not fully meeting this person`s needs.

When we previously inspected the home, we saw people were left to sit in their wheelchair for long periods of time although they were assessed being at risk to develop pressure ulcers. At this inspection we saw the same. Staff told us that it was people`s choice to remain all day sitting in their wheelchair, however this had not been documented in their care records. People told us that they stayed in their wheelchair because it was easier to ask staff to push them back to their bedroom if they wished. They explained that if they were transferred in an arm chair they had to wait for staff to transfer them back when they wanted to move. Staff had not discussed with people the risks presented to their health when choosing to sit long periods of time in their wheelchair. This meant that people were not given all the relevant information they needed to take informed decisions about taking risks.

At the last inspection we found that food and fluid charts were poorly completed with gaps in recording. As a result, people`s food and fluid intake could not be effectively reviewed to assess if they needed more support or treatment because the records were not reflective of the fluid and food they consumed. At this inspection we found that this had not improved.

Where people were identified at risk of malnutrition or dehydration food and fluid charts were in place to

monitor their food and fluid intake. The daily food and fluid intake charts we reviewed did not consistently show the person's name they were completed for nor the room number. There was no target for fluid intake specified for staff to know how much it was expected each person to drink in a 24-hour period and the amount drank was not totalled. Food intake was recorded and included information about the type of food and quantity of food consumed. However, there was no evidence that any food had been offered after 17.00 hours or if any snacks were offered between meals. There was no guidance for staff to know when to seek health professional advice in case people were not drinking or eating enough. Health professionals were contacted when people were observed losing weight. This meant that the service had systems and processes which were reactive to address people`s needs and not proactive in preventing weight loss or dehydration.

We found that the provider was in continuous breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to people's health and welfare were not sufficiently mitigated to keep people safe.

People told us that at times there was not enough staff and they had to wait for their call bells to be answered. One person said, "Usually they come quite quickly but sometimes I have to wait. Sometimes they are really busy." Another person said, "It's not too bad for me because I can do things for myself but for some people they have to wait." A third person commented, "I don't bother with my call bell in the morning I just wait for someone. You have to wait ages but it's not the carers fault, they are so busy."

A person said when asked if they felt there was enough staff around to meet their needs, "Not at night, at night there are two on this floor and if someone needs two people and lots of people do then you can't find anyone." Another person told us, "I should do the buzzer and I do but I wait so long and then I get up and go myself. If you need to go [toilet] you can't wait 20 minutes."

A relative and two people told us there were significantly less staff at weekends. Their comments included, "It's noticeable. There are less people [staff] around at weekends" and "They must think it's not as busy on a Saturday or Sunday cos there are less staff here."

Staff told us that there were issues associated with the high use of agency staff and they specifically referred to staffing problems at weekends. Staff said they worked hard to ensure that people who used the service continued to receive a high level of support when staffing was short but commented that it was difficult. One staff member stated, "Two weeks ago on a Saturday I was on the first floor on my own with the nurse. Agency staff were booked but did not turn up. I was like a chicken without a head. A colleague did come in to help with the meals." Another staff member said, "We use agency staff to fill staff vacancies but they are unreliable. Weekends are not staffed adequately because staff do not turn up." A third staff member said, "There are not always enough staff. We use agency but shifts are not always covered."

We observed throughout the day of the inspection staff being busy and not able to provide attention to people other than when they had to meet people`s needs. For example, staff brought people in the conservatory when they finished providing their personal care and left them sitting in their wheelchair or specialist reclining chair. There was no staff allocated to support people in this area and people relied on support from the activity coordinator when they were present or the staff who brought the next person in to ask for help.

We observed on occasion that staff rushed when offering support to people. For example, a person required support to eat. They were assessed at risk of choking and there were guidelines provided to staff by the speech and language therapist(SALT) team on how to support the person safely. The guidance instructed

staff to assist the person slowly and with small amounts at one time. We observed staff giving the person a two-course meal and a drink in less than seven minutes. The person coughed after they finished their meal but the staff member only said, "Are you okay?" and then carried on with their duties. This meant that the staff member was not following specialist advice when assisting the person to eat and this increased the risk of choking for this person.

There were a high number of vacant nursing and care staff hours. The deputy manager told us they were recruiting, however a high number of nursing staff and care staff left the service and their shifts had to be covered by agency staff. The deputy manager told us that although they were trying to cover the shifts as much as possible with the same agency staff to provide some continuity to people this was not always possible and agency staff were not as reliable and often did not turn up for their shifts leaving the home short.

We found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was not enough staff employed to meet people`s needs safely at all times.

People told us they felt safe at the home. One person said, "I feel safe here, I stay in my room but I feel safe and well looked after." Another person said, "If I fall over here or have a problem there is someone to help me. That didn't happen at home and I like the girls [staff] too."

Staff were able to describe what constituted abuse and could articulate how they would report concerns within the home, however they were not knowledgeable about the whistleblowing procedure. Only two staff spoken with could describe the role of external agencies such as the local authority and CQC with regard to safeguarding. All staff spoken with stated that they were confident that any issues reported internally would be addressed. One staff member said, "I am not sure what whistleblowing is."

We saw that only 78 percent of staff were up to date with the safeguarding training. Safeguarding information was not displayed on noticeboards throughout the home. The safeguarding policy was seen in the staff room but contact information for external safeguarding authorities was not detailed on it. Additionally, the local authorities safeguarding poster which is shared with services around Hertfordshire was not displayed in the home to provide useful information to people who use the service, visitors and staff in how to report their concerns. This was an area in need of improvement.

There were infection control procedures in place and regular cleaning in the home. Generally, the home was clean and there were no lingering malodours. However, the décor was dated and walls in many rooms were marked and looked dirty. In one room the curtains were marked. One person described the home as, "Well, it's tatty but quite homely."

We saw the bed linen changed in one bedroom and noted a large split in the mattress cover which we reported to the deputy manager as well as a bedrail cover flaked and ripped and this was an infection control risk. Hand sanitizers were seen through the home, although there were no signs encouraging visitors to the home to use it. Staff were seen to make use of personal protective equipment (PPE) and use it appropriately when delivering personal care to people. There were no hand washing posters seen in communal toilets which would be good practice. People were not offered the opportunity to wash or wipe their hands before their meals. The hot trolley did not look clean and food was noted to be embedded along the lower edge of the trolley. This was an area in need of improvement.

There were protocols in place for staff to know how to support people in an emergency. For example, people

had personal emergency evacuation plans (PEEP) in place to ensure in case of a fire staff had appropriate guidance in place. We saw that there were regular fire drills organised and staff were knowledgeable and confident to describe how they would act in case of a fire.

The provider had a fire risks assessment done by external company on 07 September 2017. All the actions listed were signed off as completed, however the assessment advised that it had to be revisited yearly. The provider`s representative told us the risk assessment would be carried out internally this year and only in 2019 an external company would be contracted. They could not tell us if the fire risk assessment was carried out this year by a qualified and competent person. This was an area in need of improvement.

People's medicines were managed safely. We noted that the medicine administration was completed in accordance with good practice. Medicines records were completed accurately and the sample of medicines we counted tallied with the amount recorded. Staff had received training and there were protocols in place for medicines prescribed on an as needed basis. This helped to ensure that people received their medicines in accordance with the prescriber's instructions.

We found that safe and effective recruitment practices were followed to help ensure that all staff were of good character, physically and mentally fit for the roles they performed. All staff had been through recruitment procedures which involved obtaining satisfactory references and background checks with the Disclosure and Barring Service (DBS) before they were employed by the service. Staff told us there were regular staff meetings and these were used to share any lessons learned from complaints and other incidents in the home.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy how staff supported them. One person said, "Staff are good. They know what they are doing." Another person said, "I can get what I need and staff are good to me."

Staff had mixed views about the training opportunities they were offered by the provider. One staff member said, "The training is very good, it's face to face. I am up to date and feel confident." Another staff member said, "No specialist training is offered for staff." They explained to us that staff had no specific training to understand conditions like Parkinson's, dementia or diabetes.

We saw that care staff`s training in subjects considered mandatory by the provider had lapsed. We received information from the provider`s operation support manager following the inspection that training had been scheduled in upcoming weeks to ensure that staff were updated and had their knowledge refreshed around nutrition, safeguarding, health and safety and fire safety. However more training was needed to ensure that staff were kept up to date with current best practice in moving and handling, mental capacity and deprivation of liberty safeguards and equality and diversity.

Nursing staff told us they were up to date with their training, however they expressed concerns that they were not always able to attend specific training to help them maintain their professional registration because of the shortage of nursing staff. They told us, "I am worried because I cannot have days to attend the training I need because we are short staff."

Staff told us that the management changes in the home in recent months unsettled the staff team and some staff left. One staff member said, "There was a new manager for about three months. That changed and now we have another manager but they were here for a week and then went on annual leave." Another staff member said, "I only feel supported by my team. The management and provider support is non-existent. So many manager changes and we don't know what is going on."

Support for staff in form of supervision and appraisal was not provided consistently. One staff member said, "Supervision is three monthly with a senior carer. There is the opportunity to talk about personal development." Another staff member said, "I do feel supported, but I have not had a recent supervision." Other staff told us that they felt supported by their team, however they did not feel supported by the provider.

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). At the time of the inspection, we found that all the people who were considered to require a DoLS, had one submitted and were awaiting a decision

by the local authority.

Some staff were not clear on how the principles of the MCA applied when they delivered care and support for people. One staff member said when we asked the about mental capacity, "I have not had training in MCA and DoLS, I think it is on Wednesday." Another staff member said, "I have had training in MCA and DoLS, but I have forgotten."

We heard staff asking people for their consent for the care they received on the day of the inspection. However, consent was not always clearly evidenced in care files. For example, one person`s care plan detailed that they had fluctuating capacity and their relative was involved in taking decisions in their best interest. However, consent forms in the care plan were signed by the person themselves. Another person`s care plan detailed they had capacity to deal with their own affairs and take decisions, however consent forms in their care plan were signed by their relative.

Best interest decisions were not always taken following the best interest process and evidence that the relatives involved in decisions about people`s care had legal authority to do so was not detailed in the care plans. The deputy manager told us that some relatives had legal power of attorney (POA) but were unsure if this was for financial matters or and for health and welfare.

DoLS authorisations were submitted to local authorities where people had restrictions applied to their freedom in order to keep them safe, however it was not always clear if the restrictions in place were the least restrictive measures. For example, a person had bedrails in place and they consented for these although records stated that they were confused and drowsy. There was no MCA carried out to assess this person`s capacity regarding the use of bedrails and best interest process was not completed to evidence what other measures were considered before a decision to put bedrails in place was taken. This was an area in need of improvement.

People told us they were happy with the quality of the meals provided to them. One person said, "There's plenty of food and a choice of food too." Another person said, "The food is very good. We do have a choice and it's quite fine for me."

We observed lunch served in the dining area as well as on the first floor where people mainly ate in their bedroom. On the first floor meals were served out of a hot trolley. Food came out of the trolley ready-plated and with people's name on each plate. Gravy was added to the meal without checking if this was people's preference. There was no obvious choice of portion size and not all the food was covered when taken to people in their room. Although condiments and sauces were available near the trolley, people were not offered these routinely. Staff commented, "People can have salt, pepper and sauces if they ask for them." One person had not been offered cutlery with their main meal and appeared to be struggling to eat with their hands. Staff provided cutlery for them when they served the pudding.

In the dining room at lunchtime there were 12 people with one care staff. It was clear that the staff member was under a lot of pressure to ensure every person had everything they wanted and everything was done with a smile and positive comments from them, however they had no time to chat to people. The kitchen assistant served the food which had been pre-ordered with exactly the right amount so there was no alternative food or seconds offered at the table.

Apart from one table of four people where there was a lot of laughing and joking, there was very little interaction between other people. One person told us, "I stay in my room now because there is only one table worth sitting at and it's full up now so I prefer to be on my own."

People were offered a choice of cold drinks at lunch time and in the dining room the care staff asked people if they would prefer ice cream instead of the sweet served and this was provided for the people who requested. No choice of any alternative meals was offered to people on the first floor or the ones who ate in their bedrooms. This was an area in need of improvement.

Care records showed that people were supported to access health care professionals when this was required. A hospital transfer from was seen in one care record seen which indicated that information was shared appropriately when people were admitted to hospital.

Requires Improvement

Is the service caring?

Our findings

At the previous inspection we found that people`s dignity and privacy was not always promoted by staff`s actions and therefore the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider was no longer in breach of this regulation, however further work was needed to ensure that systems and processes staff used promoted a caring and dignifying culture.

People told us staff were kind and caring. One person said, "The staff are wonderful, they are courteous, considerate and kind." Another person said, "They are really wonderful to me here."

However, staff followed some practices which promoted an institutional regime. For example, staff readily prepared breakfast bowls with cereals for the morning so people were not asked what they wanted to eat daily. People told us they had set days in a week for having a shower. One person said, "I have my shower on a Monday." Another person said, "I have an allocated shower time on a Thursday."

People`s dignity and privacy was promoted. Staff knocked on bedroom doors before they entered and where bedroom doors were left open people told us this was their choice.

Staff had no available tool or guidance to help aid communication with people who were not able to communicate verbally. Staff did not use pictures or a board with letters to assess if people who were non-verbal could communicate using these tools. For example, one person had a stroke in the past and staff assumed that they did not understand any verbal communication. When we spoke with the person they were alert and nodded. This person`s relative told us they should wear hearing aids but although they asked staff about arranging for the person to have new hearing aids this had not happened.

Another person we saw found speech difficult. We spoke to them and they showed very clearly that they wanted to go outside. We confirmed with them that this was what they wanted and they became animated and showed the outside again. A staff member went to get a blanket to support them to go outside because we asked them. We saw staff supporting this person with their meals as well and they made no attempt to communicate to them. This meant that people who were not able to make their voice heard had not been able to make choices or any preferences they may have had because there were no systems or guidance for staff to use and able these people to feel included and valued.

Positive and caring interactions were seen during the inspection and staff spoke about people in a kind and compassionate manner. There was a pleasant atmosphere in the home. Several visitors were present and joyful conversations with staff were happening. One relative was accompanied by a family friend who had been asked to do their relative's hair. The agency carer present spent time with a person in their room as was seen to be chatting in a social and friendly manner while holding the person's hand to offer emotional support. People told us their relatives and friends could visit them any time. One person had their birthday coming up and was very excited about a party they were organising. Their family put up posters inviting people to the party. They said, "I'm really looking forward to it."

People told us staff had little time to spend with them and they wished this to improve. One person said, "They are lovely but they don't have much time to talk." This was echoed by staff who told us they had no time to spend with people.

Relatives of people living in the home told us staff were quick to contact them if there was any problem or illness. One person said, "They told my family straight away and they came to the hospital." A relative said, "They phoned me just after they had phoned the doctor so that I could come in."

People told us they did not know about their care plans. We saw in some care plans that consent forms were signed by either people or relatives to agree that confidential information could be shared with relevant professionals. However, care plans were not reviewed involving people or relatives.

Care records were stored in locked cupboards and were seen to be stored securely. This meant that people's confidentiality and privacy was supported.

Requires Improvement

Is the service responsive?

Our findings

When we last inspected the home, we found the provider in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because of the lack of personalisation of the care and support people received. At this inspection we found that the provider was no longer in breach of this regulation, however more improvements were needed to ensure people were receiving person centred support.

Care plans contained information to enable staff to support people and there were some examples of person centred information. However, there was also a high level of information that was not helpful such as, 'privacy and dignity to be maintained', 'skin to be moisturised', 'trained staff to administer medication`. This was not supported by information that was personal to people such as what cream had to be used, or how people liked their dignity to be upheld.

Not all care plans had been updated following a change. For example, a care plan for a person detailed that they had an injury to their right heel. However, there was no wound chart or evidence that the injury was being checked. When asked, the nurse said the wound had now healed and this was confirmed by the person and their next of kin. However, the care plan had not been updated to reflect this change which meant that it was misleading and not up to date.

Another person's care plan said that they should be repositioned two to three hourly because of the poor condition of their skin. However, staff reported that the person was no longer on a repositioning chart because they could re-position themselves. Observation records proved that the person was mobile and repositioned themselves regularly. However, again the care plan had not been updated to reflect this change which meant that it was not up to date.

Staff did not always followed guidance in care plans. For example, a person`s nutrition care plan said that when eating the person should be in an upright position, have a break every two mouthfuls, be offered food little and often and stop if uncomfortable. However, at lunch, this person was not sat in an upright position in their bed and was not supervised during their meal. When staff took the meal to the person they did not ask if they wished to be seated in an upright position or ask if they needed support. This meant that staff were not providing people with the needed care and support.

The activity coordinator was on leave on the day of our visit and a part time activity assistant was providing activities. We saw one activity in the morning which involved three people throwing a balloon and later the staff member talking at people for 15 minutes. Some looked bored and others were asleep. In the afternoon there was a cake making activity. The same people as in the morning were around the table and when two protested mildly of not wanting to take part they were told, "You don't need to do anything. I will do it all." The activities we saw were neither inspiring nor engaging.

People told us that the main activity coordinator was better in providing activities they liked. One person said, "[Name of activity coordinator] is very good and always on the lookout for things that will make us

interested." Another person said, "In the afternoon sometimes you will see the activity coordinator or a carer in the room with the people who can't get out of bed, talking to them."

People told us they enjoyed trips out, however these were mainly in the summer. One person said, "We do go out on the bus in the summer. I like that." Another person told us they could no longer regularly go to church and they only attended the once a month service held in the home. They said, "I used to be a regular church goer but now Christchurch come in once a month for communion. That's all." Another person said, "I don't go to activities because I am worried about my catheter, sometimes it is really painful and I don't want to be stuck somewhere and not be able to get back and try to adjust it."

A group of people really enjoyed the garden and had formed a gardening group. They told us they requested more raised flower beds and the provider to check the ramps as they felt these were not safe. We saw that this was a recurrent discussion the group had in resident's meetings and there was no action from the provider to action the requests.

We recommended for the provider to develop a more structured activity programme to ensure that people in the home had regular opportunities to pursue their hobbies and interests.

The provider`s complaints policy and procedure was not displayed in the home and neither people or relatives we spoke with knew how to raise a formal complaint. One person said, "I have no idea who I would talk to." Another person said, "If it was serious I would speak to my family. I would talk to my [relative] and they would sort it out." A relative commented that, "Niggles get sorted out."

We saw that where relatives sent emails raising some concerns these were answered, however not in line with the provider`s complaints policy. Information about how to take a complaint further in case the outcome has not been satisfactory for the person who complained was not shared. This was an area in need of improvement.

People told us there were relatives and residents meetings where they gave feedback on the service provided. However, some people were not satisfied with actions taken following the issues they raised in these meetings. On person said, "I go to the meetings. Good things are proposed and some things get done and some don't." Another person said, "I go to the meetings, they talk about a lot and then you hear nothing."

The service provided end of life care for people. The staff had been prepared for this by ensuring people had their wishes documented in their care plans. Care plans showed that people were asked to think about their wishes in relation to end of life care and it was documented if they had any. Where people were nearing end of life action was taken to keep them as comfortable as possible and to remain at the service if this was their choice. The deputy manager told us that they were working in partnership with staff from a local hospice. This partnership working ensured staff from the home had support from end of life care specialists in meeting the needs of the people who were nearing the end of their life.

Requires Improvement

Is the service well-led?

Our findings

When we last inspected the home, we found the provider in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a lack of contemporaneous records and lack of effective audits to identify and improve the quality of the care people received. At this inspection we found this had not improved enough and the provider was in continuous breach of this regulation.

People and staff told us there were a few managers changes over recent months. People did not know who the manager was. One person said, "We've had so many changes, I don't know a name." Another person said, "I don't know who the manager is, I'd talk to the office if I needed to talk to someone I suppose." A relative told us, "I have no idea who the manager is."

The previous registered manager has been replaced by an interim manager for a few months and a new manager has been employed and started at the home only two weeks before this inspection. However, they were on leave on the first day of the inspection so we returned for a second day to meet them and discuss about their initial assessment of the service and the care provided to people.

There were various audits carried out by the provider, deputy manager and regional support manager. Areas audited included care plans, medicines environment and others. A service improvement plan was in use where the improvements needed were listed. We found that some actions were signed as completed, however the date of completion was extended to 31 August 2018 and were still outstanding at the date of the inspection. For example, care plans were not always up to date, mental capacity assessments and best interest decisions were not always carried out in accordance with the principles of the Mental Capacity Act and people were sitting long periods in their wheelchair.

Audits carried out were not always effective in finding all the issues found in this inspection. For example, audits had not identified that not all the risks involved in people using and operating their own wheelchairs were assessed and mitigated as far as possible without restricting people`s free movement. People were not given all the relevant information to weigh up and make informed decisions about taking risks.

Risk assessments were not developed for people who were choosing to sit long periods of time in their wheelchairs. They had not been provided with information on how this decision could impact on their health.

We received information from service commissioners who carried out an audit at the home in February 2018. The actions resulting from this audit were signed off as completed, however we found that these were not sustained. For example, the commissioners found that there was no safeguarding information or poster displayed in the home. This had been signed off as completed in March 2018, however at the inspection we had found that this was still outstanding. Commissioners identified that actions resulted from meetings, regional mangers visits or audits were not consistently addressed and completed. They recommended that actions were signed off by the manager or regional manager when these were checked and completed. We

found at this inspection that this was still an area in need of improvement as actions were not consistently signed off.

The provider had not been proactive enough to improve the quality and safety of the care provided to people and achieve a good standard. This was the third consecutive time when the overall rating for the service has been Requires Improvement. We found that there was a high number of permanent staff vacancies at the home. Staff we spoke with said that a high number of staff left over a period of several month and this was confirmed by the deputy manager. There was now a recruitment drive and some staff had been waiting for pre- employment checks so they could start at the home, however the provider had not been proactive enough to address this issue sooner. As a result, for some of the job roles required in the home there were more vacant hours then the hours filled by permanent staff. For example, there were total of 110 nursing hours filled with permanent staff, however 132 hours were vacant.

There was a rolling redecoration plan in place to ensure that some areas of the home got re- decorated. However, we found that the redecoration of the home had been slow and the provider relied mainly on the maintenance staff to carry out redecorations as well as other maintenance duties. The environment looked tired and dated.

The provider limited people`s choices by not having bath facilities in the home only showers. Only two bedrooms had a bath, however these were not suitable to use for less mobile people. There were people living with dementia accommodated in the home and current studies showed that at times showers could be distressing for these people. We recommended that this information to be made available to people and their relatives when they enquired for a place in Highfield Care Home and the service user guide to detail this.

We found the provider in continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not improved their governance systems enough to ensure that people received care and support which was safe and at a good standard.

The home had a newly employed manager in post. They told us they were still assessing all the areas of the service and prioritising their work. They said one of their priorities was to address the staffing issue in the home and they were currently advertising for permanent staff vacancies.

They said the provider fully supported them and this was confirmed by the provider`s operation support manager. The provider`s operation support manager told us they were fully supportive of the manager and had made all the resources available to them to implement changes and improve the service.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The provider had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and welfare were not sufficiently mitigated to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider`s governance systems were not effective enough to ensure that people received care and support which was safe and at a good standard.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not enough staff to meet people`s needs safely at all times.