Inspection Report

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

Highbury Residential Care Home

38 Mountsorrel Lane, Sileby, Loughborough, LE12 7NF

Tel: 01509813692

Date of Inspection: 09 November 2012

Date of Publication: December 2012

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✓ Met this standard
Safety and suitability of premises	✖ Enforcement action taken
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Sudera Care Associates Limited
Overview of the service	Highbury Residential Care Home is registered to provide accommodation and personal care for up to 27 older people and those with dementia. The home is situated in the village of Sileby with access to local shops, cafes and other facilities. It can be reached by public transport and there is parking in the grounds.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

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

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Highbury Residential Care Home had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Safety and suitability of premises
- Staffing
- Assessing and monitoring the quality of service provision

This was an unannounced inspection.

How we carried out this inspection

We reviewed all the information we have gathered about Highbury Residential Care Home, looked at the personal care or treatment records of people who use the service, carried out a visit on 9 November 2012 and observed how people were being cared for. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

We carried out this follow-up inspection due to concerns against a number of outcomes which were inspected in August 2012. We re-visited the home to assess whether the provider had made sufficient improvements to the service.

As part of this inspection we spoke with three people who used the service, four members of staff working at the service, and two relatives of someone who was using the service.

People using the service told us they were generally happy living at the home. One person commented, "I think it's got a lot better. There's a lot more staff on and there's more help for us." Two people we spoke with told us they did not think they were allowed to go out of the home for a walk or allowed to go to their bedrooms during the day. One person said, when asked if they could go for a walk, "I don't think they'd let you do that." Another person told us they did not think they were able to use their bedroom during the day.

Staff reported to us that numbers of staff had been increased and that people's needs at the home were now being met. We observed sufficient staff on duty during our visit. One staff member told us, "A lot of changes have happened at the home. We used to struggle with a shortage of staff but now we have enough staff. I can see many changes."

We reviewed care plans at the service and found that these had been improved on since our last inspection.

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

What we have told the provider to do

We have asked the provider to send us a report by 22 December 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Highbury Residential Care Home to protect the health, safety and welfare of people using this service.

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

People's views and experiences were not being taken into account in the way the service was provided and delivered in relation to their care.

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

Reasons for our judgement

We looked at this outcome as a result of speaking with people who used the service and due to concerns we had from speaking with the manager of the home.

People using the service told us that they did not believe they were able to access the local community should they wish to as this was 'not allowed' by the provider. Two people we spoke with told us that they would like to go to their own bedroom during the day but again said they did not believe this was permitted.

We looked at an activity schedule which had been recently implemented at the home. This detailed a number of activities planned for people each day. However, we were not told, nor did we see any evidence, that people had been asked about what activities they would like to undertake on a daily basis. People were not being given choices about what they did at the home and where they spent their time.

Meetings for people using the service had not been carried out prior to our visit in August 2012. At this inspection we found that one meeting had been held for people using the service on the 22nd August 2012. During this meeting people were asked about the menu at the home and about whether they would like to go out on a day trip. No other meetings had been held at the home since our previous visit and the provider was unable to evidence how people using the service were being given an opportunity to express their views about how the service was being run.

During our inspection we looked at all of the bedrooms, some of which had been recently decorated. We asked the provider about the decor of these rooms and whether people were able to choose how their rooms were decorated. The provider had not taken steps to ask people how they would like their personal bedrooms decorated. We did not see evidence on activity schedules, in meeting minutes or in care plan that people were involved in making decisions about their care

People using the service were not always being treated with dignity and respect by the staff working at the service. We observed people's rooms being entered without staff knocking on the door. People were not given choices about how they spent their time at the home and were, for the majority of the day, sat in the communal lounges without the choice of accessing their own rooms should they wish to.

The provider had not ensured that staff working at the service had received training on person-centred care or on dignity and respect. We did not see any evidence of staff training on these areas.

There was limited assurance that people using the service were being treated as individuals and given choices about how they spent their time.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

We reviewed four care plans for people using the service. There had been some significant improvement by the provider in relation to the care plans. We found these to be well-presented and easy to follow. Do not resuscitate forms were in place where appropriate and hospital grab sheets had been completed. Weight charts were completed and we saw evidence, within the plans we looked at, that timely referrals had been made to health professionals.

We reviewed charts for people who needed to be turned regularly by staff as they were at risk from getting pressure sores. We found that these charts were being completed and recorded by staff. We also saw that staff were making daily logs which were up-to-date and which detailed any care given. Staff were making accurate and appropriate records to ensure the safety and welfare of people using the service.

We found that risk assessments were in place for people and were appropriate for the people they concerned. The care plans detailed what care should be given in a number of key areas to ensure the well-being of the person using the service.

We saw evidence that care plans were being reviewed on a regular basis and saw some significant improvements had been made in planning and assessing people's care. We also saw evidence that the provider was recording care being given to ensure this was safe and appropriate for people using the service.

We observed people to be more engaged and active within the home during our follow-up inspection. We saw evidence that more activities were taking place for people. We did not see evidence, however, of how people had been given choices about what activities they took part in.

We observed people's care needs being met during our visit. There were sufficient numbers of staff on duty to ensure that people using the service were being adequately cared for and that care records were kept up-to-date. Staff we spoke with reported that staffing levels had improved and that, as a result of this, so had the care being delivered to the people using the service.

Safety and suitability of premises

✖ Enforcement action taken

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who use the service, staff and visitors were not being protected against the risks of unsafe or unsuitable premises.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Following our last visit to the home we asked the provider to tell us how they were going to improve the environment in which people were living. We concluded from our inspection in August that people's bedrooms were not being adequately maintained to ensure the safety of the people using the service.

When we returned to the home for this inspection we did a complete tour of the building, accompanied by the manager. We checked everyone's bedroom and looked at the house maintenance programme for the year. This ran from August 2012 to July 2013.

The maintenance plan the provider had put in place detailed some re-painting, both to people's bedrooms and to the communal areas of the home. We saw that four rooms on the plan were in the process of being re-decorated. When we looked at these rooms we saw some of them had already been re-painted. The provider told us that people had not been consulted on how the rooms would be decorated. None of the furniture in these rooms had been replaced.

We looked at people's beds and saw that four mattresses and bed bases we looked at were soiled and were not in good condition. Some people's beds were old and were in need of replacing. Many of the wardrobes we looked at had doors which did not close properly. We observed a cracked and broken mirror in one bedroom which was hazardous for the person occupying it. We saw a floor divider between the bedroom and bathroom was raised and was therefore a trip hazard for the person occupying that room.

Two people living at the home had fire doors from their bedrooms and one fire exit was partially blocked by the bed which may have prevented people from being able to exit the building in the event of a fire. We observed fire doors which were hanging off their hinges and one door which did not close properly because of this. This was not safe for people occupying those rooms. Several door handles on people's bedrooms were not working properly and presented a risk for people opening and closing their bedroom doors.

Some of the bedrooms we went into smelt strongly of urine. The carpets were not in a good state of repair and needed replacing. This meant that people's bedrooms were not being adequately maintained to ensure the welfare and safety of people occupying them.

During our last visit to the home we saw that equipment was being stored in communal areas. One cupboard, in a communal hallway contained wheelchairs which were overflowing into the hallway. This was still the case when we re-visited the home and continued to present a risk to people moving about the home, many of whom had some form of dementia.

We reviewed the home's fire safety assessment and saw that recent fire tests and checks had been carried out. However, we did observe a fire exit which was being blocked by someone's bed.

We saw that maintenance checks had been carried out on the lifts at the home. We looked at the last maintenance record for one of the lifts and noted that an item was in need of repair. When asked about this the manager was unable to provide any further details on this and was not clear on what the issue was.

The maintenance plan for the home was not adequate and insufficient improvements had been made at the home. There was no audit being carried out in relation to the physical environment of the home. People's safety was not being taken into account and risk assessed by the service. Overall we found there was inadequate building maintenance taking place at the home and so people were at risk from unsafe premises.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

On the day of our inspection there were four carers on duty at the home, one home manager, one cook, two housekeeping staff, one member of maintenance staff and one kitchen assistant. There were 17 people living at the home at the time of our visit. We observed people's needs being met by adequate numbers of staff on duty. People we spoke with who used the service told us that they felt their needs were being met. People did comment that they felt staffing levels had improved. The relatives of someone using the service told us, "Things have improved recently."

Staff we spoke with all felt that, since the staffing numbers had been increased at the home, things had improved, both for themselves, and for the people using the service. One staff member told us, "Now there is enough staff. There wasn't before but there is now." We observed buzzers being responded to in a timely manner and people being attended to as and when required. There were no delays in people's personal care needs being met.

We observed lunch-time at the home as we had done on our initial visit. We saw that lunch-time was much calmer and that people were not having to wait for long periods of time before receiving their food. People were alert and enjoying their meal. Staff appeared to be managing this more effectively than during our last inspection. This was an indication that staffing levels had been improved upon.

We looked at the training schedule at the home and although this had not been fully updated by the provider, key gaps in training had been filled since our last visit. Staff had recently had updated training in first aid, pressure sore care, care planning and health and safety. The provider may wish to note that the training schedule we reviewed had not been updated. Further training gaps were planned to be filled by the provider and we were told that this was being arranged at the time of our inspection.

We looked at supervision records and saw that some staff had received supervisions with their manager. Those who hadn't were booked in to have one in the near future. The provider had taken steps to ensure they were monitoring the training and development needs for staff working at the service.

Staff files were up-to-date and held all the relevant information and checks.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

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

Reasons for our judgement

During our last visit to the service we found that the service was unable to produce any evidence of how it had sought the views of people using the service. Since this inspection in August 2012 the provider had held one meeting, during August, for people using the service. This meeting had been documented and did provide some evidence that people had been asked for their views on how the service was being run. However, some of the actions from this meeting had not been carried out by the service and there had been no meetings since the one held in August. We visited the home in November and could not see sufficient evidence that the service continued to consult people about how the home was being run.

The provider had issued questionnaires to people using the service and their families following our last visit. Five of these had been returned. The results had not been collated by the service at the time of our inspection.

The provider was carrying out audits on care plans and we saw evidence of these. No other audits had been implemented following our last visit. The provider was unable to demonstrate to us how they were monitoring the systems in place at the home.

The home environment that people were living in was not of an adequate standard. Many of the door handles to people's bedrooms were not working, some doors, including fire doors, were hanging off their hinges and some people's beds were soiled. The provider was unable to show us evidence of how the environment in which people were living was being checked and maintained. We did see a maintenance plan which was in place but this did not include any audits or checks being carried out on the physical environment. Risks associated with living at the home, in terms of the maintenance of the building, were not being assessed or managed effectively by the provider.

We asked the provider, following our last inspection, to tell us how they were going to improve their quality monitoring of the service. Having re-visited the home and reviewed actions in this area we did not see enough evidence of sufficient improvement to make the provider compliant with this regulation.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: People were not being given choices about how they spent their time at the home. People's privacy and dignity was not always being respected. People were not being treated as individuals.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: No audits were being carried out on the building. The provider was not adequately seeking the views of people using the service. Quality monitoring was not sufficient to reduce risks for people using the service, particularly in relation to the physical environment they were living in.

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

The provider's report should be sent to us by 22 December 2012.

CQC should be informed when compliance actions are complete.

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

This section is primarily information for the provider

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✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 28 December 2012 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: There was no audit being carried out in relation to the physical environment of the home. People's safety was not being taken into account and risk assessed by the service. There was inadequate building maintenance taking place at the home and people were at risk from unsafe premises.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

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

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

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

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

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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