Inspection Report

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

Highbarrow Residential Home

Toothill Road, Uttoxeter, ST14 8JT

Tel: 01889566406

Date of Inspection: 22 April 2013

Date of Publication: May 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Management of medicines	✗ Action needed
Safety and suitability of premises	✗ Action needed
Requirements relating to workers	✓ Met this standard
Staffing	✗ Action needed

Details about this location

Registered Provider	Sunplee Limited
Registered Manager	Miss Amanda Jane Wilne
Overview of the service	Highbarrow Residential Home can accommodate 22 people. They are not registered to provide nursing care.
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

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 22 April 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. 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 inspection to check on the care and welfare of people using this service. The inspection was unannounced which meant the provider and the staff did not know we were coming. We spoke with five people using the service, three staff and the registered manager.

Where people were not able to express their views we observed interaction between people and the staff. We saw staff provided sensitive support and people using the service were treated with respect. One person told us, "The girls know what they're doing, and they ask us what we want."

There were limited activities within the home and there were no specific services provided for people who had dementia related conditions. One person told us, "We like playing the word games, but some people aren't able to join in." This meant people could not be confident all their identified needs were being met.

Information about when people needed additional medication was not recorded to demonstrate why it was necessary. This meant people could not be confident they had all medication as prescribed and required.

The staff told us they enjoyed working at the home. We saw that all the checks were made to ensure staff were fit and suitable to do their job.

The staffing was not arranged to ensure people could have all their assessed needs met appropriately. Staffing arrangements did not allow for the safe evacuation of people in the case of an emergency.

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 05 June 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Fire officer, Fire Officer and Fire Safety Assessor. We will check to make sure that action is taken to meet the essential standards.

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 ✓ Met this standard

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 meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

People we spoke with understood the care and treatment choices available to them. Our previous inspection identified concerns with how people were supported to make choices with their personal care and bathing.

During this inspection, people told us they were able to choose when they wanted a bath. One person said, "I could have a bath every day if I wanted one. I tend to have one twice a week but could have more if I wanted." Another person told us, "The staff try very hard here and let us know we can choose what we want to do."

Our previous inspection identified people were not able to choose when to retire or get up in the morning. We spoke with three people using the service who told us they could now choose when to get up and go to bed. One person told us, "We tell the staff what time we want to get up, and they come to us around that time. We don't have to get up if we don't want to." Another person told us, "I go to bed after supper. The staff ask me when I'm ready." This meant people were now able to have a choice about their daily routine.

People were supported in promoting their independence within the home. People we spoke with told us they were able to retain their independence in relation to personal care and how to spend their time. One person said, "The staff know what I can do and they know I'm safe. If I was no longer safe I'd tell them, but I'm happy the way things are."

People told us they could choose whether to spend time in their room or join other people. We saw one care record recorded that a person using the service did not want to eat their meal in the main dining room but use a table over their seat. We saw that this decision was respected at lunch time. This meant people were able to make decisions and these were respected by staff.

People's diversity, values and human rights were respected. People we spoke with told us they were able to participate in a religious service in the home. One person told us, "We can have communion here if we want to. I also have a visit from my local church." Another person told us, "I'm not bothered what denomination they come from. There's only one

God, and I'm happy to carry on worshipping. They are lovely people who visit here." The staff confirmed that some people chose not to participate in religious activities and this was respected. The current arrangements met the needs of people using the service which meant people were able to continue to practice their faith.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People did not always experienced care, treatment and support that met their needs and protected their rights.

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

People's needs were not always appropriately assessed. One person had recently been admitted to the home and the registered manager told us they had not carried out an assessment to determine whether the service could meet the person's needs. The registered manager had not met the person prior to admission, and had not given them information about the service and how their needs could be met. This meant the registered person had not established how to provide suitable care for this person, and keep them safe.

We looked at the care record for this person and saw that information relating to their care had not been recorded. There was an assessment completed by the local authority which explained the support the person needed in their own home within the community. This meant the staff did not have information to deliver care in a safe consistent way within a residential home. We spoke with the person who told us they were happy with the support provided and said, "The girls are brilliant here. They always ask me what I want, and they listen." The staff told us the person was able to tell them how to provide care but this had not been recorded to ensure the person received safe and consistent care, treatment or support.

We looked at three care records for the people we spoke with during our inspection. We saw the care records were being reviewed and rewritten in a person centred style. This meant they focused on how people wanted their care to be delivered and included individual personal information. We saw the care was tailored to their individual wants and needs. There was information about identified risks in relation to moving and handling and falls. We saw these were reviewed monthly to ensure the care records were up to date. This meant that the care records were being reviewed to ensure people were receiving appropriate care.

Some people's care and treatment did not always reflect relevant research and guidance for people with dementia. On the day of our inspection, a word game was played in the main lounge and people were encouraged to participate. People spoke positively about

this game and told us, "I like playing the word games on the white board. They're always fun."

We saw there were not any activities or specific interaction for people with dementia or for people who could not actively participate in this game. One person told us, "We don't have much to do here really. I like to read but some people aren't able to do that." This meant some people using the service were not supported to meet all their individual diverse needs.

During the morning of our inspection, we spent time in the main lounge area and we saw one person had a photograph book. This displayed photographs of important people and events. We saw a staff member talk to the person about the photographs and the person responded positively and smiled. One member of staff told us, "They love looking through this and remembering people." We asked the registered person what other activities were carried out to support people with dementia and whether other people had photo books or life stories. The registered manager told us there were no other specific activities carried out in the home for other people with dementia. This meant people with dementia could not be confident their needs would be met.

Management of medicines ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

Medicines were kept safely in a locked cabinet. Senior care staff were responsible for managing and administering medicines. There was a register of medicines delivered to the home, held in stock and disposed of. The registered manager was able to produce these. We audited three people's tablets and saw that all medicines were properly accounted for. This meant the registered manager could be confident the amount of medication recorded was available in the home.

Appropriate arrangements were not in place in relation to the recording of all medicine. We saw two people needed 'when required' (prn) medication. A protocol detailing when prn medication should be administered was not in place. When prn medication was administered, it was recorded on the medication administration record (MAR) but not within the records as to why this had been required. This meant people using the service could not be confident there was clear information as to why and when prn medication was needed.

The MAR sheets were completed after each person had taken their medication as required. This meant the service reduced the possibility of mistakes. We checked the MAR charts for three people and found they were all correct.

Safety and suitability of premises ✖ Action needed

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 using the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises

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

The provider had not taken suitable steps to provide care in an environment that was suitably designed and adequately maintained. The home did not have any visual signs to support people to move safely around the home or to find their bedroom or a bathroom. All the bedrooms doors looked the same along the ground floor corridor, and only displayed people's names in small print. Two people using the service told us some people entered their bedroom uninvited, and they did not have a key to lock their bedroom when it was not occupied. One person told us, "I was told I could have a key, but I never got one. I'd like to keep my things safe and private." This meant arrangements had not been made to keep personal possessions safe.

A fire officer from Staffordshire Fire and Rescue Service had visited the service in September 2012. They identified concerns with the fire safety arrangements and had sent a report to the registered person. The registered manager told us some work had been completed and a second visit by the fire officer would be carried out to ensure the work was completed to a suitable standard.

In response to the fire officer's report, the registered person had arranged for cold smoke seals to be fitted to the bedroom doors. This had resulted in the bedroom doors not shutting properly. This meant the doors would not act as an appropriate fire door in the event of a fire and could place people at risk.

Six bedroom doors along a corridor of eight bedrooms had been wedged open. Fire door guards which were linked to the fire system were not fitted. This meant they would not close and presented a greater fire risk to people. We highlighted this with the registered manager who removed the objects and closed the doors as required to keep people safe. We have shared our concerns with the fire officer.

We looked at the fire records and saw there was a record of weekly and monthly tests of the system as reccommended. There was a record of when fire evacuations had taken place and who was involved. This meant people could be confident that the fire system

was suitably maintained.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, and experienced staff.

Reasons for our judgement

Our previous inspection identified that the necessary recruitment documentation was not in place for all staff working in the home. During this inspection, we looked at two staff files who had been recently employed within the service. We found that appropriate checks were undertaken before they had begun work.There was evidence there had been checks for each person's suitability to work in the home, including written references, satisfactory disclosure and baring checks (DBS), application forms, health and identity checks. These checks would help to keep people safe and prevent them from harm as they had taken steps to prevent unsuitable people working at the home.

There was evidence that new staff had been provided with induction training so they knew what was expected of them in their role. We spoke with one member of staff who had recently started to work in the service. They confirmed they were completing their induction and receiving the training needed to carry out their role.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs at times in the day and at night.

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

There were not enough qualified, skilled and experienced staff to meet people's needs at all times during the day and night. The staff roster recorded there were generally three care staff on duty throughout the day up to 5pm. From 5pm and overnight there were two staff on duty. The staff and people we spoke with confirmed this.

The service provided accommodation on two floors and people had bedrooms on the ground floor and first floor. The registered manager and staff confirmed to us that there were three people with complex needs may require the support of two staff when they needed assistance with personal care. This meant that during the evening and night both members of staff could be supporting one person and would not be available to respond to other people during these periods. This meant people could be placed at risk.

The main lounge had one call bell, which was located on the fireplace wall. We asked two people using the service how people were able to summon for assistance. People told us they sometimes just had to wait until a staff member appeared. One person told us, "If things go wrong or we need help, we have to get up and call for staff. Not everybody can walk. I've had to call for staff on behalf of someone who couldn't walk." This meant people did not have access to staff at all times and did not have access to a call bell system to summon staff when needed.

A fire officer from Staffordshire Fire and Rescue Service had visited the service in September 2012. They identified there was insufficient staffing to evacuate people from the service in the event of a fire or where people were in imminent danger. The current design of the building and number of bedrooms within a fire zone meant people using the service may not be safely evacuated by the number of staff on duty.

The fire officer completed a report and sent this to the registered person. Within the report it gave actions that should be take and to reduce the risk. The fire officer issued a timescale for action and will revisit the service to check compliance. We have shared our concerns with the fire officer.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person had not taken proper steps to ensure that each person was protected against the risks of receiving care or treatment that was inappropriate or unsafe. This was because an assessment of needs was not carried out for all people and the planning and delivery of care did not met some peoples needs.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The registered person had not protected people using the service against all risks associated with the unsafe use and management of medicines.
Regulated activity	Regulation
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:

This section is primarily information for the provider

	The registered person had not ensured that people using the service and others having access to the premises, were protected against the risks associated with unsafe premises.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The registered person had not safeguarded the health, safety and welfare of people using the service as there were not sufficient numbers of staff at all times working in the service.

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 05 June 2013.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk