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: 25 October 2012

Date of Publication: November 2012

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

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Management of medicines	✖ Action needed
Requirements relating to workers	✖ Action needed
Complaints	✓ Met this standard

Details about this location

Registered Provider	Sunplee Limited t/a Highbarrow
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 25 October 2012, 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

Some people using the service told us they were happy with the care and support provided. They said the staff were patient and kind. One relative told us, "I think it is fantastic here."

Other people using the service did not consider they were able to make choices. They told us the staff decided when they went to bed, had a bath or were woken. One person told us, "I have a bath once a week when they can do it, it depends who is waiting."

We observed the staff and saw they provided sensitive support, and people were treated with respect. People using the service said the staff would always knock on their door.

We looked at care plans and talked to the staff about the care that was provided. We found information was conflicting and some staff had not read the care plans. This meant the provider could not ensure people had their needs met in a consistent and safe way.

We checked medication was stored, dispensed and administered in a safe way. We found people using the service were not suitably protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We looked at the recruitment procedures for staff and found that overall suitable systems were in place but the provider had not ensured all records were completed to protect people using the service.

We found complaints were responded to and the provider acted upon concerns to improve the service.

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 04 December 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

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 privacy, dignity and independence were respected but choices were not always made available.

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

We spoke with five people who used the service; two of these people expressed some dissatisfaction with their care. Their concerns were around waiting for care, a lack of baths and having limited choice.

We asked people using the service if the staff treated them with dignity and respect. People using the service confirmed the staff were respectful and considerate. One person said, "They always knock, they are polite and kind, some are very kind. It's not an easy job for them." Another person said, "They are very good to me."

When we talked to people using the service we were informed that some choices were limited. People using the service told us, "They have so many people to deal with; I can wait up to 20 minutes for my bell to be answered. They will normally pop their head round and say they will come as soon as they can." Another person said, "I had my hair washed this morning, I was told that this was happening, bath and hair wash. But they haven't dried my hair, they haven't got the time. I have to sit here with it wet." Another person using the service told us, "They tell me when to go to bed; they say come on now it's time to get undressed." Someone else said, "I get up when they come for me." This meant that some people were not offered the choice of when to rise and retire. For people who were not able to make these decisions the care records did not offer any information to demonstrate how decisions had been made in their best interests.

We saw some positive interactions and heard the staff ask people using the service what assistance they wanted and we heard them explaining what they were doing. We were able to evidence that where people were mobile, this mobility was encouraged. This meant people using the service were able to maintain their independence.

We asked two people who used the service what they had chosen for breakfast. We were able to see that what was requested was provided. This meant that choices were considered in these instances.

There was little information to show that people's diversity, values and human rights were respected. The provider may wish to note that information relating to these should be included within the plan of care.

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 experience 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

When we arrived at 6:40 am six people were dressed and sitting in the lounge. Nineteen people were in residence. We were also aware of one person who had also been supported to get ready for the day in their room because the night staff informed us of this.

We saw there was a list of ten people in the office which read, night staff. This meant the night staff were responsible for getting those people ready for the day. The night staff informed us they would only do this if it was the person's choice or if they required assistance due to continence management. We checked care records to see if this information was recorded. There was no information available to reflect how these decisions had been made. This meant it was not possible to ascertain if the person had been able to make the decision. We identified that all the people who were already up and sitting in the lounges when we arrived had a dementia related condition.

Comments from people using the service who were able to inform us about how the home was run included, "Things have to be done when they want it, and I get up when they come for me." Another person said, "I don't like waiting about to go to the toilet, sometimes I have to ring my bell a number of times." Another comment was, "They insist on undressing me a couple of hours before I want to go to bed." Positive comments included, "The staff are very good, I am satisfied." Another person said, "I am more than happy, I like my room and the staff are kind."

We looked at the plan of care for two people who used the service and spoke to staff about people's needs, as well as the individuals concerned. This is called pathway tracking and helps us to better understand whether the care planned for and delivered was meeting people's needs on an individual basis.

We saw that each person had a plan of care that gave basic information about their needs. The plans of care were not centred on the person and did not always offer staff clarity. For example, two people had an alarm mat placed on the floor. This was to alert the staff when they got out of bed. There was no record of how this decision had been made, or if it was in the person's best interests. We saw conflicting information in plans of care. For

example, an assessment from the local authority stated two staff were required for transfers and the risk assessment undertaken by the home indicated only one person was required.

One person told us the staff lifted them from the chair and it was uncomfortable for them on occasion. We looked at the care records to see if the staff had clear information to explain how to transfer the person. The information was minimal; it said, 'use the stand aid.' It did not offer information on how this was done. This meant the staff may inadvertently cause discomfort for the person, and the risk of developing pressure sores may be increased. Having agreed plans of care which are clearly recorded would ensure people had their needs met in a consistent and safe way. This would protect the person and other people living and working at the home.

We looked at records for bathing and saw that some people had not received a bath on a regular basis. A staff member told us the baths would have been provided but not recorded. They said these would be recorded on the computer. We checked these records on the computer and saw that only one of the three baths over a month had been recorded. This meant that it was not possible to ensure if people had received the care they required.

We looked at the weight records for people and saw that people had been weighed four times over a 12 month period. This should be completed on a monthly basis. We saw three people had not been weighed for a year; this was because they were unable to stand. The staff told us that sit on scales had been requested and the provider knew these were necessary. Not having these records meant there was no monitoring regarding weight gain or loss for these people.

Under current fire safety legislation each person requires a fire safety risk assessment; these were not evident in people's care records. The personal emergency evacuation plan (PEEP) needs to provide information to support people who cannot get themselves out of a building unaided during an emergency situation. This meant the necessary information was not available to support vulnerable people.

We looked at care plan reviews which were completed monthly. These mainly recorded no change or recorded, 'as per care plan.' One recent review stated 'mobility' but it did not say why or what had changed. We looked back at the mobility care record and saw no changes had been made to the care plan. This meant records were not always up to date or amended as required.

We saw the records showed that individuals' personal and healthcare needs were being monitored. A family member confirmed that the doctor was requested as required. They said, "They are good at keeping me informed and I am confident the home call the doctor if needed."

A visitor told us that reviews were completed with people using the service and the family. This ensured their views were captured and that their wishes and preferences could be included in their care records. We saw that care records had been signed by people using the service to show they were involved and had agreed to the content of the care and support they received.

We were informed by one new member of staff that they had shadowed the staff. This meant they had been an extra member of staff on duty so were afforded the time to learn and experience what was required. We asked this member of staff if they had looked at

any care records for people who used the service, they said they had not. This person had been employed for a number of months. This meant the provider could not be assured that care support and treatment were being delivered as required.

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.

The provider had not taken all reasonable steps to protect people against the risks associated with the unsafe handling and management of medicines.

We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

We arrived at Highbarrow Residential Home at 6:40 am we went into the unlocked office at 06:45. We saw that ten people's morning medication had been taken out of the blister packs by the senior carer for the day shift. They had been placed into pots on a tray, these pots were not labelled. This meant staff were dispensing medicines that were not labeled properly or legally, and the medication was not identifiable in any way. Due to the office being open anyone could have walked into the office and ingested or taken medication. The staff on duty also informed us that some people using the service 'wandered.' This meant the risk of people walking into the office was increased.

The member of staff told us they had done this when they came on duty at 06:30. We asked the member of staff if they knew what they had done was unsafe. They said that they did. We asked why they had done this and they told us, "Because I have seen other members of staff doing it." This member of staff told us that they had recently completed training on medication management but felt they were still new to it and had seen other staff members preparing medication in this way.

This practice was unsafe and placed people who used the service at real risk. There was the potential for tablets to be given to the wrong person or for someone to take tablets from the tray and ingest them, which could have caused serious harm. We informed the registered manager of this at the time of our findings.

Care workers can only give medicines to people from the container that the pharmacist or dispensing GP had provided, anything else is known as secondary dispensing, no matter how briefly the medication is in another container. We were informed the tablets were for the morning medication round. This meant the tablets would be in pots for approximately two hours and were at risk of being contaminated.

During our inspection these pots of tablets were moved into the medication trolley. This meant the tablets were rearranged, and the service could not guarantee that the way they had been dispensed was the way in which they would be administered. The service could also not guarantee people using the service would receive the right medication.

We also saw one tablet on the filing cabinet which was loose on a piece of paper. When we returned to the office it was not there. We asked the manager about this but they said they were not aware a tablet had been placed there. It was not possible to ascertain if this tablet had been administered, lost or disposed of. The manager did not know who the tablet belonged to or how long it had been there. This meant the home could not be assured people had been given their medication as prescribed.

We checked the medication systems used by the home later in the day and we found that the medication for the week was stored in the office in a locked trolley which was secured to the wall when not in use.

The service had secure storage for medication and the monitored dosage system was used for most medicines, which meant they were dispensed into monthly blister packs. We looked at the way in which medicines were administered for two people using the service. The medication administration records (MAR) for the two people were also inspected as part of this process.

We audited a sample selection of the number of tablets coming into the home and the number that had been prescribed from the blister packs. These were correct and medication records and administration records tallied.

We looked at the medication record for one person who had 'as and when required' (PRN) medication and saw that a protocol was not in place. These should be available and demonstrate the decision making processes for PRN medication, to validate when medicines were administered. We checked this person's records and saw there was not any information about how or why this had been decided, and saw the MAR chart was blank. This meant it was not clear why the medication had not been either offered or administered. The registered manager told us the person using the service would say if they required the medication but this was not recorded Providing a protocol would ensure the staff had clear information on why and when to provide certain medication.

We saw controlled drugs were stored separately and safely, and were recorded in the controlled drugs register as required. The service was recording information relating to controlled drugs in a suitable manner. The provider may wish to consider removing items from the cabinet that were not medicines .

Requirements relating to workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Appropriate checks were in place but the provider had not always ensured all records or suitable evidence was in place to confirm vulnerable people were suitably protected.

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

We looked at two staff files. The files held some appropriate documentation including application forms, and proof of identification. Only one reference was evident in each file. This meant not all the necessary documentation was available as required. If references were not forthcoming the provider should evidence these were requested and followed up on as far as was practicable. There was not any information available to verify this action had been taken.

We saw on one file there was a seven year employment history gap with no record of what occurred during this period of time. This meant that not all the necessary information was available to ensure appropriate people were employed to work with vulnerable people.

We could see that the provider had obtained Independent Safeguarding Authority (ISA) and Criminal Records Bureau (CRB) checks for both of the staff prior to working with vulnerable adults. The start dates were not apparent on their staff files. We asked the manager to inform us when these staff members commenced work to ensure it was after the CRB date recorded. The registered manager could provide this information from the rotas.

We asked to see information to verify induction had taken place. The manager told us they had no records for new staff's induction when these were in progress. We did see a completed record for one member of staff who had worked at the home for some time. The registered manager told us that for one member of staff they had not been happy with their progress. We asked to see a record of this but the manger told us they had written these concerns on, "scraps of paper" and had no formal record. This meant there was no evidence to support the provider in ensuring suitable staff were working at Highbarrow Residential Home.

Complaints

✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available.Comments and complaints people made were responded to appropriately.

Reasons for our judgement

People told us they would speak with the staff if they were worried. One person said, "I feel safe here."

People we spoke with thought the staff were kind and patient. A visitor told us, "I would be happy to mention to the staff if I had a problem or concern." A relative confirmed that they were contacted when needed and kept updated. We looked at the complaints log and saw one complaint was recorded with the action and outcome.

We saw the complaints procedure was available in the hall but information was lacking, clarity regarding who to complain to, other than the manager was required. The provider may find it useful to note that they should update their complaints policy and procedure to offer clear and accurate information. A suggestions box was not available so people could not offer their views anonymously.

There wasn't any information in the home regarding advocates or advocacy services. The provider may wish to consider ways of ensuring people using the service could ask for an independent person to support them with decision making.

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: The registered person must so far as reasonably practicable, make suitable arrangements to ensure that service users are enabled to make or participate in making decisions relating to their care and treatment.
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 must take proper steps to ensure that each service user is protected against the risks of receiving care that is inappropriate or unsafe by means of meeting the service users individual needs.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers**
	How the regulation was not being met:

This section is primarily information for the provider

	The registered person must operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity by means of ensuring that information specified in Schedule 3 is available.

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 04 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.

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

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