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: 04 November 2013

Date of Publication: December 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Care and welfare of people who use services	✖ Action needed
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

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 4 November 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, talked with staff and reviewed information sent to us by commissioners of services. We reviewed information sent to us by other authorities.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

We completed this inspection to follow up on issues we identified when we last inspected this service on 19 August 2013. We found concerns during the previous inspection in relation to care and welfare of people using the service and with the staffing provided in the home.

We found that some improvements had been made. There were more opportunities for people to engage in activities appropriate to their abilities. However, we were concerned that some people may be at risk during the evening and night as there were not enough staff on duty to meet people's identified needs and respond to emergencies.

We saw that staff engaged with people in a caring and friendly manner, but there were occasions when people did not receive prompt support from staff. Some people had been placed at risk as agreed care plans and assessments of risk had not been followed to prevent harm.

People's care records contained up to date information although care had not been planned in a way which would guide staff to deliver care in accordance with people's needs. This placed people at risk of harm.

There remains poor outcomes for some people and therefore the service will be subject to a management review by us. This is a key part of the enforcement process whereby we set out what we will do to get the care provider to improve their service. The action we will take will depend upon what effect this is having on the people using the service and how the care service provider responds.

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

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

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.

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

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 nine care records for people using the service and saw these contained an assessment of need which included information about their history, personal preferences and their views about the care treatment and support provided.

We saw the care records included information about people's general health and identified health concerns. One person had lost a significant amount of weight over the period of a month and developed a pressure sore. The registered person had not identified this as a concern which required escalating. A visiting health care professional had been reported this to the local safeguarding team, as they were concerned about the person's health and that care plans had not been followed to prevent further harm. Since this referral we saw that the care plan devised by health professionals was now being carried out and the person was supported to change their position to prevent further skin damage. We saw that the person had also been seen by a mental health care professional to review changes in behaviour and had been seen by a doctor to review how care and support was provided. This meant staff were now addressing identified concerns and had responded to changing needs.

Since our last inspection on 19 August 2013, a fire officer from Staffordshire Fire and Rescue Service had carried out an inspection and identified that fire exits and doors on escape routes could not be easily opened in the event of an emergency. The registered person told us they no longer used a key to lock the door to ensure people could be safely evacuated. Some people using the service would be at risk of harm if they left the home without assistance. The registered person told us a risk assessment had not been completed and no action had been taken to ensure people were safe and could not exit the home unsupervised. The staff told us that one person had left the home without their knowledge through the unlocked door. They told us the person had been injured as a

result and needed medical attention. This meant the registered person had not taken any action to reduce the risk to people using the service which had resulted in actual harm being caused.

The registered person had carried out an investigation following this incident and recorded that to ensure people were safe, the door should be alarmed. The registered person told us that this work was going to be done in the near future. However, on the day of our inspection, this work had not been carried out and the staff confirmed that no other safety measures had been put in place. This meant suitable action had not been taken to reduce the identified risk and protect people from further harm.

On our previous inspection, we identified that there were limited activities available for people using the service. The registered person told us that an activity coordinator had been employed and was visiting the home on the afternoon of our inspection. We could not see any information for people using the service to tell them what activities were going to take place or when they would take place. We asked two people about the activities and they told us that they knew that someone came and they enjoyed some of the activities, but people did not know when the next visit would be or what activities might be taking place. This meant people were not informed about activities taking place in the home.

We spoke with the activities coordinator who explained that they worked in the home three afternoons each week which included occasional weekend working. They said that they had wanted to post details of the days and activities in advance but the home didn't have a notice board. They told us they had been able to speak to people using the service to explore what activities they wanted to be involved with. We observed as people joined in the activities including playing hoop and ball games and we saw people were laughing and talking with each other about the activities. One person told us, "She's lovely, she gets us all involved."

There were two call bells in the lounge for people to raise an alert if they needed support. We spoke with two people using the service and they told us some people could not rise from their seats unaided and would not be able to summon support. One person told us, "Sometimes we have to call for other people if they want something or need the toilet." This meant care had not been planned to ensure people's welfare and staff were reliant on assistance from other people who used the service to identify when people needed assistance.

We spent some time in the main lounge of the home and observed how staff interacted with people they cared for. We looked at the people's care records to check information matched the care and supported we observed being given. We saw that people were comfortable in the presence of staff and they reacted positively when staff spoke with them. Members of staff made periodic visits to the lounge and spoke with people. We saw one member of staff interact with three of the nine people in the room, looking at a newspaper and discussing the news and looking through a memory book with one person. Each interaction was ended abruptly as the staff member was called to, or responded to the needs of the next person. We spoke with the member of staff and they said, "It's always busy. It would be nice to have more time with people". We spoke with two relatives who told us, "It's always like this, sometimes we have to get things for people because there's no staff around." This showed that staff had a good relationship with the people they cared for, but didn't always have time to provide for people's emotional needs.

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

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 inspection on 19 August 2013, we identified concerns about the number of staff on duty to meet people's needs at all times of the day and night. The registered person advised us that a new member of staff now lived on the premises and was available to be called upon by the staff if they were busy. The registered person told us there was no formal system to alert the extra member of staff, and told us, "They would just shout." There was no record of when additional staff had been required nor details of when they were available. One member of staff we spoke with told us, "They always let us know when they are available, but we don't have anyone when they go out."

On the day of our inspection the additional support staff was on annual leave and no other arrangements had been made to provide additional cover. This meant in case of any emergency there was no additional staff available in the home, which could place people at risk.

The home provided accommodation on two floors and people using the service had bedrooms which were located within different parts of the home. The registered person confirmed to us that there were five people who needed the support of two members of staff with personal care or support to move. When only two staff were on duty, both members of staff could be supporting one person and would not be available to respond to other people during these periods. The registered person informed us that staffing had not been reviewed against the dependency levels of people using the service. This meant that some people may not receive care and support in a timely manner.

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 people were not at risk of receiving inappropriate care. The planning and delivery of care did not always ensure the welfare and safety of people using the service.
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 taken appropriate steps to ensure that at all times there were sufficient numbers of staff to provide care and support to people using 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 11 December 2013.

CQC should be informed when compliance actions are complete.

This section is primarily information for the provider

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

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