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: 19 August 2013

Date of Publication: September 2013

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

Care and welfare of people who use services	✖ Action needed
Management of medicines	✔ Met this standard
Safety and suitability of premises	✔ 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

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

- Care and welfare of people who use services
- Management of medicines
- Safety and suitability of premises
- Staffing

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 19 August 2013, observed how people were being cared for and talked with people who use the service. We talked with staff and talked with other regulators or the Department of Health.

What people told us and what we found

This was a responsive follow up inspection to Highbarrow residential home. We wanted to see what the service had done to improve on areas we had identified in a previous inspection which had needed improvement. We also wanted to look at areas which had been highlighted to us as concerns by people who used the service or people acting on their behalf. The previous inspection took place on 22 April 2013.

In order to make our judgements we spoke with eight people who used the service, five members of staff, and we liaised with a fire safety officer at the regional fire and rescue service.

We found that some care records contained conflicting information, staff did not always know what people's needs were, and people did not always receive care in a responsive and timely manner.

Medication was kept safely and given to people as prescribed.

The buildings had been improved to ensure they were compliant with current fire safety legislation.

Staffing levels meant that at some times of the day people did not always receive the care they needed when they needed it. One person said, "They do their best".

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 12 October 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 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

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 planned and delivered in a way that was intended to ensure people's safety and welfare.

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 arrived at Highbarrow residential home at 6am. We found there were 16 people using the service. When we walked through the home we saw that ten of the 16 bedrooms which people occupied had had the doors wedged open with chairs or upturned stools. We saw that a fire door on the first floor which gave access to two rooms had also been wedged open with a chair. When the registered manager arrived at the home she removed these obstructions and said, "They shouldn't be doing this. It will stop". A member of staff said, "We have to check people every hour, so it stops us having to disturb them". Wedging open bedroom doors and fire doors meant that people in those rooms were exposed to the risk of fumes in the event of a fire or from tripping if they tried to leave or re-enter their room.

People told us they were happy living at Highbarrow residential home. They said the staff were kind and compassionate and helped them with their needs. One person said, "These girls are lovely, they are, they deserve a medal". We saw that staff spoke politely to people who used the service and treated them with respect in how they approached and dealt with them.

When we inspected previously in April 2013 we found that some people who used the service had not been properly assessed prior to being accepted into the home. Assessments had not always been completed when people arrived at the home to ensure their needs could be met. The registered manager had provided us with an action plan outlining how the service would improve in this area. During this inspection we saw that improvements had been made. We saw evidence of how the registered manager had visited a prospective resident and carried out an assessment prior to the person coming to the home. The person did not subsequently choose to use the service, but the registered manager explained the processes which she had put in place to ensure assessments would be completed. This meant that people who were proposing to use the service could

be confident that their needs would be fully assessed, and the home would only provide the service to people they were capable of supporting.

Some of the people who used the service at Highbarrow residential home had more complex needs than others. We saw that whilst some of the people were quite independent and could do most things for themselves a number of people needed the assistance of a care worker to perform some tasks. Some people required two care workers to assist them. We asked staff how many of the people who used the service required the assistance of two care workers. Some staff we spoke with were not sure of all the people who needed two care workers. The registered manager explained that five people required two care workers to assist them with some of their needs. We checked the care records of four people who used the service. We found discrepancies in some records between the overview of the care plan and the manual handling assessment. The overview suggested one care worker was sufficient to provide support while their manual handling assessment identified two staff were needed. We saw that the personal evacuation plan overview which was displayed in the entrance of the home identified only three people as needing the assistance of two care workers not five as identified by the registered manager. This meant that there was conflicting information and people who used the service were at risk of receiving inappropriate or unsafe care.

When we inspected previously we found that some people's treatment did not always reflect relevant research and guidance for people with dementia. In order to address this the registered manager explained that they were in the process of recruiting an activities coordinator. She explained some of the activities and suggestions which the service intended to introduce for people with dementia. She told us, "She's just waiting for the disclosure and barring service (DBS) to get back to us and then she will be starting". The DBS carries out important checks which help ensure staff are suitable to work with vulnerable people. This showed that the service had responded to the need to provide a more stimulating environment. However, at the time of our inspection this support had not yet started which meant people with dementia and similar conditions were still not receiving diversionary based activities.

We had been contacted regarding an issue whereby it was suggested that untrained domestic staff had assisted care workers in providing personal care to people who used the service. We spoke with the domestic worker who was on duty at the time of our inspection and they assured us that they did not assist with personal care. When we spoke with the deputy manager of the home she said, "We had one day when we were very short staffed and without any notice a care worker phoned in and said she was not coming to work and was finishing. The domestic who had worked in a care home before assisted for a very short time until extra staff could attend. We had a complaint from a social worker about it. It was not allowed to happen again". This meant the service had taken steps to ensure only properly trained and qualified staff provided peoples personal care.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

During our previous inspection of Highbarrow residential home in April 2013 we had found issues with the way medication was stored and administered. As a result of these issues being highlighted, staff had received additional training and new policies had been introduced which had resulted in improvements in this area. At our last inspection we identified that the provider still needed to address concerns regarding medication which is prescribed to be taken as required. This medication is known as (prn) medication. During this inspection we saw that a new prn protocol had been introduced. People's records had been amended to reflect their prn medication needs and medication administration records were being updated to reflect when people took or declined their medication. This meant people's medication was properly accounted for and a clear record was available of any medicine they had taken.

We saw the service had systems in place for the safe management of people's medication. This meant that medication was kept safely, was given to people as it had been prescribed and disposed of safely when no longer needed.

Safety and suitability of premises ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

During our previous inspection of the home in April 2013, we had received information from the fire and rescue service regarding concerns about the layout of the premises and lack of fire compartments. Fire compartments are barriers within buildings which block smoke and flame and give people time to evacuate a building safely. The fire safety officer had found that additional fire doors had been required to bring the building up to modern standards. Again the registered manager had provided us with an action plan to address the problem. On this inspection we saw that additional fire doors and screens had been built which meant that the building was now safer and in the event of an emergency people would have more time to escape.

We saw in the fire and rescue officers' report the service had been required to fit cold smoke seals on a number of doors, however these had resulted in the doors not closing properly and therefore the doors would not function properly in the event of a fire. We saw that these had been adjusted and the doors now operated correctly.

The registered manager explained how one person who used the service had requested that their door be left open. This person was being transferred to a newly refurbished room and an automatic door closer was being fitted so that the person could have their door open, but in the event of a fire alarm the door would automatically close. She said, "I think we need to look at fitting these to all the bedroom doors".

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.

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 it was inspected in April 2013, we found that Highbarrow residential home did not have enough qualified, skilled and experienced staff to meet people's needs at all times of the day and night. During this inspection we found that there had been no change to the levels of staff providing personal care. The registered manager advised us that they had recruited an additional care worker but they had also had one leave which meant the staff numbers had remained constant. She did advise us about the new activities coordinator who was due to start work. However, the activities coordinator would not be providing personal care and would not impact on the busy periods when people who used the service needed more assistance.

The registered manager explained that a new member of staff lived on the premises and was available to be called upon by night staff if they were busy. We spoke with the member of staff who confirmed the arrangement. However this member of staff had been one of the two staff working that night and confirmed that she had worked other night shifts. This meant that there was no additional staff if she was out or already working nights.

We found previously that there were only two staff available on night shifts to cope with the needs of all the people who used the service including three people who had been identified to have complex personal needs which required two care workers to assist them. During this inspection we found that the staffing levels had not changed and there were now five people who had been identified as needing the assistance of two care workers. This meant the workload for staff was higher than it had previously been, and people who used the service remained at risk of not receiving the care they needed in a timely and efficient way.

Staff we spoke with had different views on the level of care they were able to provide. One member of staff said, "Two is enough". They went on to explain how they thought they could manage with two care workers. Another member of staff said, "We cope at the moment because there are only 16 people, but if there is any illness and people need more support we just don't have time". People who used the service told us they thought

staff did their best but sometimes in the mornings and evening when people were rising for breakfast or going to bed, they had to wait because staff were busy. One person who used the service said, "I've had to wait 15 minutes sometimes". They went on to describe how on one occasion they had needed the toilet and because staff had not responded they had been unable to hold themselves. Another person who used the service said, "They can't come to you quickly when you ring the bell if they're dealing with someone else". This meant that at times the service was not responsive to people's needs.

The fire safety officer had commented in their report that they believed there were insufficient staff at night to evacuate people safely. This had been mitigated to a degree by the addition of the new fire doors which would slow smoke fumes and flames. However, the increase in the number of people with complex needs meant there were more people who would need assistance from both care workers on duty. This meant that people who used the service could not be confident that they would be safely evacuated if the need arose.

We have shared our findings with the fire and rescue service.

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 service user was protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of planning and delivery of care in such a way as to meet the service users individual needs, nor ensure the welfare and safety of the service user, nor reflected where appropriate, published research evidence and guidance issued by appropriate professional and expert bodies as to good practice in relation to such care and treatment. Contrary to Regulation 9, subsection 1(b)(i)(ii) and (iii) of the Health and Social Care act 2008 (Regulated Activities) regulations 2010.
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: There were not sufficient numbers of suitably qualified staff at all times to safeguard the health safety and welfare of service users. Contrary to Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

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 12 October 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

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