Mrs Susan Burns and Mrs Marion Burns

Highfield House Residential Home

Inspection report

17 Sycamore Terrace
Haswell
County Durham
DH6 2AG
Tel: 0191 5261450

Date of inspection visit: 29 June 2015
Date of publication: 22/09/2015

Overall summary

We carried out an unannounced comprehensive inspection of this service on 15 and 16 December 2014 and informed the provider they were in breach of a number of legal requirements including the management of medicines, consent to care and treatment and assessing and monitoring the quality of the service.

After our inspection in December 2014, a healthcare professional from the infection prevention and control team raised concerns about the infection control arrangements within the service and the lack of progress made towards complying with an action plan from an audit undertaken in April 2015.

The registered provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook this unannounced focused inspection on the 29 June 2015 to review the action the provider had taken to address the breaches. We also discussed the concerns about infection control with the registered manager and looked at the improvements made in this area. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Highfield House Residential Home on our website at www.cqc.org.uk

Highfield House Residential Home provides care and accommodation for up to 25 people. On the 29 June 2015 there were 16 people using the service.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We saw the provider had taken measures to ensure people were protected against the risks associated with the unsafe use and management of medicines.

We found the provider was implementing recommendations from the infection prevention and control audit undertaken in April 2015.

We discussed the Deprivation of Liberty Safeguards (DoLS) with the registered manager. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We found the provider had made applications under the Mental Capacity Act Deprivation of Liberty Safeguards.

Summary of findings

We found evidence of mental capacity assessments or best interest decision making in the care records and staff were following the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions.

We saw the provider had introduced a new system to record the views and comments from people who used the service, their relatives, visitors or stakeholders about the quality of the service provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
We found that action had been taken to improve the safety of the service. People were protected against the risks associated with the unsafe use and management of medicines.

The lighting in the main downstairs corridor of the home had been improved and restrictors had been fitted to the two large windows in the rear upstairs bedrooms.

We found the service was managing the control and prevention of infection.

We could not improve the rating for: is the service safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service effective?
We found that action had been taken to make the service more effective. Staff were following the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions and the provider had made applications under the Mental Capacity Act Deprivation of Liberty Safeguards.

We could not improve the rating for: is the service effective from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?
We found that the service was well-led. People using the service, their relatives, visitors or stakeholders were asked about the quality of the service provided.

Accidents and incidents were recorded and an accident analysis was up to date. Risk assessments were communicated to staff and action plans were included in audits.

All the people in the service had a Personal Evacuation Plan in place.

We could not improve the rating for: is the service well-led from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Highfield House Residential Home

Detailed findings

Background to this inspection

We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

During this inspection we checked to see what improvements had been made since our last inspection on 15 and 16 December 2014. We reviewed the action plan the provider sent to us following that inspection and we found that the assurances the provider had given in the action plan in order to become compliant with the regulations had been met.

This inspection was undertaken by two adult social care inspectors on 29 June 2015 and was unannounced. We inspected the service against three of the five questions we ask about services: is the service safe, effective and well-led. This was because the service was not meeting some legal requirements at our previous visit.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and enquiries raised. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. A healthcare professional from the infection prevention and control team raised concerns about the services lack of progress made to comply with an action plan from an infection control audit undertaken in April 2015. We discussed the concerns about infection control with the registered manager and looked at the improvements made in this area.

During this inspection we spoke with the registered manager, the registered provider, a relative of a person who used the service, three care workers and a healthcare professional. We looked at the personal care or treatment records of four people who used the service and observed how people were being cared for.

Is the service safe?

Our findings

At our inspection in December 2014 we identified concerns that the provider had not taken proper steps to ensure people were protected against the risks associated with the unsafe use and management of medicines. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider had ensured improvements were made in this area and these had led the home to meeting the above regulation.

A relative we spoke with told us they thought their relative was safe at Highfield House Residential Home. They told us, "Yes, I know she's safe."

We discussed the medicines procedures with two senior carers and looked at records. We saw medicines were stored securely in a medicine store room which was kept locked at all times when not in use. We looked at the medicines administration charts (MAR) for five people and found one omission which was addressed at the time of our inspection. Records were kept for medicines received and disposed of.

We looked at the provider's medicines policy and we saw that medicine audits were up to date. We saw that temperatures relating to refrigeration had been recorded daily and were between 2 and 8 degrees centigrade. We saw that temperatures for the treatment room were recorded daily and they were less than 25 degrees centigrade. The fridge and treatment room temperatures were within the recommended temperature ranges. Staff who administered medicines were trained and their competency was observed and recorded by senior staff. This meant that the provider stored, administered, managed and disposed of medicines safely.

We saw that the two lights in the main downstairs corridor had been repaired. The improved lighting in this part of the home was now appropriate for older people or those with dementia as it would reduce people's anxiety and the risk of trip or fall accidents. We also saw restrictors had been fitted to the two large windows in the rear upstairs bedrooms. This meant that people could not climb out and reduced the risk of falls.

After our inspection in December 2014, a healthcare professional from the infection prevention and control team raised concerns about the infection control arrangements within the service and the lack of progress made towards complying with an action plan from an audit undertaken in April 2015. We discussed these concerns with the registered manager. The registered manager told us about the measures she had taken to comply with the action plan which included arranging infection control training for all staff on 25 June 2015, implementing mattress audits and replacing equipment. We looked at the improvements made and spoke with the healthcare professional who told us, "I have delivered training and ten staff attended. Work towards the completion of the action plan is well in progress and the service appears to be taking our recommendations and advice forward". This meant the service was managing the control and prevention of infection.

Is the service effective?

Our findings

At our inspection in December 2014 we identified concerns that the provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider had ensured improvements were made in this area and these had led the home to meeting the above regulation.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We discussed DoLS with the registered manager and looked at records. She told us that she was in the process of reviewing all care plan documentation and sourcing further mental capacity training for staff. We found the provider had made applications under the Mental Capacity Act Deprivation of Liberty Safeguards and staff were following the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions. The registered manager told us, “I feel more confident when assessing capacity and when deprivation of liberty should be applied for”.

We found evidence of mental capacity assessments or best interest decision making in the care records and staff were following the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions. The registered manager told us that she had arranged further training for staff about the Mental Capacity Act 2005 and (DoLs) in August 2015.

Is the service well-led?

Our findings

At our inspection in December 2014 we identified concerns that the provider did not did not gather information about the quality of their service from a variety of sources. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider had ensured improvements were made in this area and these had led the home to meeting the above regulation.

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. The registered providers were also present.

We looked at what the provider did to check the quality of the service. We saw the provider's audit file, which contained a range of audits including maintenance records, care plans and fire safety. All of these had last been audited in May 2015 or June 2015 and had action plans in place.

Accidents and incidents were recorded and the registered manager reviewed the information in order to establish if there were any trends.

We looked at the provider's Business Continuity Plan and saw all the people who used the service had a Personal Emergency Evacuation Plan in place. This described the emergency evacuation procedure for the home and for each person who used the service. This included the person's name, room number, impairment or disability and assistive equipment required.

Risk assessments were in place and each one contained a read and sign form for staff. This meant that staff were made aware of potential risks within the service and how to manage them.

We looked at what the provider did to seek people's views about the quality of the service. We saw evidence that a comments book had been put in place and people using the service, their relatives, visitors and stakeholders were asked about the quality of the service provided at Highfield House Residential Home. All the comments we saw were positive about the standard of care provided by the service. This meant that the provider gathered information about the quality of their service from a variety of sources.