Dhillon Care Services Ltd

Highview Home

Inspection report

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West Midlands
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Highview Home is a residential care home providing accommodation and personal care for up to 24 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 21 people using the service.

People's experience of using this service and what we found
Medicines were not managed safely which placed people at risk of harm. Risks to people from the environment were not always highlighted or effectively monitored. When people were involved in an accident or incident, the provider didn't always review this to learn lessons and reduce risks to people in the future. Despite this, people felt safe at Highview Home and there were enough staff to meet their needs.

Quality assurance systems were not always effective for people. Audits monitoring the quality of the service were not consistently completed and up to date. This meant the action taken by the provider had not always ensured people received consistent, good and safe care. However, people spoke positively about Highview Home and relatives felt their loved ones were well cared for. Systems were in place to seek feedback and resolve people's complaints.

People's care plans and risk assessments did not always assess their person-centred needs. People living with dementia weren't always supported with accessible information to assist them to make choices. However, people and relatives felt staff knew them well and understood their likes and dislikes. The provider ensured daily activities took place and these were tailored to what people found enjoyable.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 08 September 2022) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was carried out to follow up on breaches found at the last inspection. The inspection was also prompted in part due to concerns received about the management of accidents and incidents and the governance of the service. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to how people's safety was managed and how the service was run at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Highview Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
Two inspectors carried out this inspection.

Service and service type
Highview Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Highview Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a manager in place as they had recently left their post at Highview Home. The service was being managed by the Nominated Individual.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us

annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people and five relatives about their experience of the care provided. We spoke with five professionals who have contact with the service. We spoke with 12 members of staff including the nominated individual, senior carers, carers and an activity coordinator. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included six people's care plans, medicine administration records (MAR) and two staff recruitment files. We viewed a variety of records relating to the management of the service including audit systems.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely; Assessing risk, safety monitoring and management

At our last inspection we found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People's medicines were not safely managed. We found the amount of medication in stock for several people did not reflect the electronic records. Some people had more medication than expected and others had significantly less. This meant we could not be assured people had received their medications as prescribed.
● A new electronic medication administration record (MAR) system had recently been adopted by the provider. Previous medication audits showed that issues with stock counts of people's medicines had previously been identified, but no action had been taken to address the concerns.
● Staff had their competency assessed prior to starting to administer medicines to people. However, there was no system in place to ensure staff handling medicines had regular competency assessments, in line with good practice guidance.
● People had protocols in place for 'as and when required' PRN medicines. However, these were not readily available to staff and a senior carer who showed us the electronic system was unable to find where this information was held. The provider took immediate steps to ensure these documents were accessible to staff.
● Actions were not taken to support people who had lost weight. We saw people were weighed by the provider, but there was a lack of analysis of people's weights and steps were not taken to seek guidance or medical intervention for people who continued to lose weight. Staff were unsure if any people were at risk of losing weight and therefore lacked knowledge about who may need to be supported and monitored more closely. The provider took immediate steps to address this.
● Care plans did not always contain details to guide staff about people's health needs. For example, care plans were not in place to inform about people who took medicine that thinned their blood. The provider had already identified this issue and had created a reference list for staff. However, staff were not always knowledgeable about how the medications impacted people's health needs. This meant there was a risk staff would not respond appropriately if a person taking this medicine had a fall or injury.
● The safety of the environment was not always monitored. We observed areas containing hazardous

materials were behind coded doors. However, the codes for the locks were written on the doors. This put people at risk of harm. The provider removed these on the day of the inspection.
● Audits that monitored the safety of the environment, such as regular checks of the fire alarm and emergency lighting, were not up to date. The provider conducted these audits shortly after the inspection.

We found no indication that people had been harmed. However, systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They conducted a full medication audit and conducted safety audits in the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Learning lessons when things go wrong
● Systems were not effective in identifying trends following incidents, with a view to reducing the risk of further incidents in the future. Accidents and incidents were only occasionally reviewed by the registered manager and audits were not consistently completed. This meant there was the potential that learning could be missed.
● The provider was open and transparent about shortcomings identified before the inspection and the steps the service was taking to address these. The nominated individual was receptive to the issues highlighted by the inspection and took immediate actions to ensure people were safe.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe at Highview Home. One person said, "I am looked after very well. If I need anything, I press my buzzer and someone comes."
● Systems were in place to identify, report and investigate any safeguarding risks to people. Incidents were recorded and referred to the Local Authority safeguarding team where appropriate.
● Staff had received safeguarding training and understood the signs of abuse and how to report any concerns they may have.

Staffing and recruitment
● Staffing levels were maintained at the assessed level to support people safely. We saw there were adequate staff available to meet people's needs during our inspection. Where people asked for help, they were supported immediately.
● Two staff files showed staff members had been recruited appropriately. The provider had completed past

employment and police checks before the staff members started at Highview Home to make sure they were suitable to work with people.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

At the time of our inspection, Highview Home was not facilitating visitors due to positive COVID-19 cases in the home. However, systems were in place to support visits to the home in line with current guidelines.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.
At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our last inspection the provider had failed to ensure that people were supported with personalised care that reflected their needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9. However, there were still areas of improvement identified by the inspection.

● Care plans and risk assessments did not always contain details to guide staff about people's person-centred needs. For example, one person who had previously displayed behaviour that could challenge, did not have a care plan in place about how to support them if they became distressed. This meant that staff members may not have had the appropriate knowledge required to respond to the person's needs.
● Before our inspection, we received feedback from professionals who shared concerns about the knowledge of the staff team in relation to managing a specific health need. The provider had taken steps to ensure additional training was planned to address this.
● Staff were generally knowledgeable about people's likes and dislikes. People felt the staff knew them well and were attentive to their needs. One person told us, "The [staff] are very good, very caring. They are very helpful, all of them."
● The provider had employed an activity coordinator at the service and people were supported with activities daily. We observed individual and group activities taking place which appeared enjoyable for people.
● Relatives told us they were happy with the activities available for their loved ones. One family member said "[My relative] does little activities. [The activity coordinator] is so nice, the other day they were dancing with residents in the lounge."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● The service didn't always ensure communication was dementia friendly. We observed people with

dementia having difficulty choosing which meal they would like, as they didn't understand what was on offer. The provider told us they had plans to ensure pictures of meal options were available in the future to assist people to make choices.

● People had communication plans in place and staff understood people's communication needs. For example, one staff member told us how they looked at facial expressions, gestures or changes in a person's mood to assess whether they may be trying to communicate they were in pain.

End of life care and support

● There was an inconsistency in the documentation used by the service to explore and record people's end of life wishes. This had been identified by the provider and steps were being taken to ensure people's views and beliefs were clearly recorded.

● People's friends and relatives had been consulted about the end of life needs of their loved ones.

Improving care quality in response to complaints or concerns

● The provider sought feedback from people, relatives and professionals. Any concerns raised were dealt with and those involved were updated.

● The provider had a system in place to record, respond to and review any learning from complaints received.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection we found the provider had failed to ensure effective systems were in place.
This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Medication audits had not been completed for three months prior to our inspection, despite the previous audits identifying issues of concern. The audit system in place only reviewed stock counts of medicines and didn't record other safety considerations such as the security of the medication trolley or the expiry dates of items with a short shelf life. This meant that we could not be certain that systems ensured people's medicines were stored and administered safely.
● Monthly provider audits were not up to date at the time of our inspection. This included audits which monitored safety, such as fire alarm testing and hot water temperature checks.
● Accidents and incidents had not been consistently reviewed by the provider. Where systems were in place to identify trends or learning, these were only completed occasionally. This meant there was no effective system to review and reduce risks to people following incidents at the home.
● Systems were not effective in highlighting issues with the environment. The nominated individual conducted a daily walk around of the service. However, this had not identified that codes were displayed for secure areas, or where people had access to items that could cause harm to others.
● The provider's processes had not ensured care plans and risk assessments always contained key information about people's health needs. One person's care plans and risk assessments were contradictory about their needs. Another person's needs due to their medication were not documented. Systems in place had not identified these shortfalls.
●The governance systems had failed to ensure fire safety information was accessible and up to date. People's fire evacuation plans had been formulated but were not easily accessible for staff in the event of a fire. An emergency plan that listed people's needs in an evacuation had not been updated to include new admissions or people on temporary placements.
● Systems and processes in place had failed to identify the issues we highlighted during the inspection. This

was the third CQC inspection where a breach in the governance of the service was found.

Systems and processes were not established to ensure service users received safe, quality care that meets their current needs. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Prior to the inspection we identified that CQC had not been notified about a serious injury a person at Highview Home had sustained. This had been an oversight by the service. The provider sent a retrospective notification after the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● We received mixed feedback from professionals about Highview Home. Prior to the inspection we had been advised of concerns about the safety and governance of the service. During the inspection, other professionals told us the provider was responsive to people's needs.

● Relatives told us communication with the provider was good and they would feel confident to raise any issues with management. One relative said, "If anything changes, they will tell me." Another family member explained that staff had worked collaboratively with them to make a decision about their relative's belongings.

● Systems were established to seek feedback from people, family and visitors to the service. We saw previous feedback had been analysed and was positive about the service people received.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Relatives told us that they felt their loved ones had a good quality of life at Highview Home. Two family members told us that their relative's health and wellbeing had improved since moving to the home.

● Staff spoke positively about their roles and felt that morale within the team was good. One staff member said, "People are really nice, it's like a family." Another staff member told us, "I think everyone is happy. They all have smiles on their faces."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found no indication that people had been harmed. However, systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of proposal to impose positive conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established to ensure service users received safe, quality care that meets their current needs. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of proposal to impose positive conditions on the provider's registration.