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Haighfield Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service:
Haighfield Care Home provides personal and nursing care for up to forty-five people. It is a purpose built home spread over four floors. At the time of inspection 28 people were living at the home.

People's experience of using this service:
People and their relatives spoke positively about the home and standard of care provided, telling us they would, "Recommend the home to anyone, it is excellent."

People received safe care which met their needs. Staff had received training in safeguarding and knew how to identify and report any concerns. Sufficient staff had been deployed to care for people with procedures in place to cover any shortfall due to holidays or sickness absence. Medicines were managed safely by staff who had been trained and assessed as competent to do so. The home was clean, odour free with effective cleaning and infection control processes in place.

People received effective care from a staff team who had received appropriate training, ongoing supervision and support. An admission assessment had been completed for each person, to ensure the home could meet their needs and for people to discuss the care and supported they wanted. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. People spoke positively about the meals provided and we found people requiring a modified diet received these in line with professional guidance.

People told us staff were kind, caring and treated them with dignity and respect. People had developed positive relationships with the staff, who had taken the time to get to know people, their likes dislikes and interests. People were encouraged and supported to express their views and have involvement in the running of the home.

Staff supported people in a responsive way. Care plans were in place which explained how people wanted to be cared for. These had been reviewed regularly to reflect people's changing needs and wishes. The home had an effective complaints procedure, which people were aware of, though very few had needed to use. Where people had chosen to discuss their end of life wishes, these had been captured. The home actively supported people to remain at the home at the end of their life and ensured staff had received the necessary training to facilitate this.

The home was well-led and managed. People, their relatives and staff spoke positively about the manager and deputy manager, who were reported to be friendly, approachable and willing to listen. A range of audits and quality monitoring were completed to ensure the standard of care was maintained and any issues identified and addressed. Action plans had been generated and completed to promote continuous employment.

The home met the characteristics for a rating of 'good' in all key questions. More information is in the full report.

Rating at last inspection:
At our last inspection the home was rated as 'requires improvement'. The last report was published on 26 January 2018.

Why we inspected:
This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received. Inspection timescales are based on the rating awarded at the last inspection and any information and intelligence received since we inspected. As the home was rated as 'requires improvement' following our last inspection, we returned within 12 months to check the necessary improvements had been made.

Follow up:
We will continue to monitor information and intelligence we receive about the home to ensure care remains safe and of good quality. Due to the improvement in rating, we will return to re-inspect in line with our inspection timescales for good services, however if any information of concern is received, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below

Is the service well-led?

Good

The service was well-led.

Details are in our Well-Led findings below

Haighfield Care 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC), a bank inspector and expert by experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Haighfield Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection:
The first day of inspection was unannounced, which means the home did not know we were visiting.

What we did:
Prior to the inspection we reviewed information and evidence we already held about the home, which had been collected via our ongoing monitoring of care services. This included notifications sent to us by the home. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay. We also asked for feedback from the local authority and professionals who work with the home.

Prior to the inspection we did not ask the service to complete a Provider Information Return, which is

information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people living at the home and six visiting relatives. We also spoke with the registered manager, deputy manager and seven staff members, which included health care assistants, supervisors and the chef.

We reviewed six care plans, four staff personnel files, seven medicine administration records (MAR) and other records relating to the management of the home and care provided to people living there.

Good

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 in November 2017, we rated this key question as 'Requires Improvement.' This was because we identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as systems and processes in place to protect people from abuse and improper treatment had not been operated effectively. At this inspection we found improvements had been made and the provider was now meeting this regulation. People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse:

- People and relatives we spoke with commented on the high standard of care provided. Everyone we spoke with felt they or their relatives were safe. Comments included, "'Yes, I feel very safe. The staff are always on the ball and so I am well looked after", "I feel safe because I can ring the bell and someone will come to see me…I like living here because it is a community and we all know each other and I feel safe because of that" and "Mum is very safe. I visit at different times of the day and I have never been concerned about anything I have seen."
- Each staff member we spoke with knew the different types of abuse and how to identify concerns. Safeguarding training had been provided and refreshed annually, to ensure knowledge remained up to date.
- The home's safeguarding file contained copies of the local authority's reporting guidance, which we saw had been followed. Wigan Council use a 'tier reporting system', with minor issues classed as a tier one and safeguarding issues classed as a tier three. The safeguarding file had been separated into sections for each tier level, with a log in each section which contained details of what had occurred, action taken and outcomes.
- Information about safeguarding was located in the home to ensure anyone who had concerns knew how to report these.

Assessing risk, safety monitoring and management:

- Care files contained a range of risk assessments which provided staff with clear guidance to follow and helped keep people safe.
- Ongoing monitoring to maintain people's wellbeing and safety had been completed. Accidents, incidents and falls had been documented consistently as per company policy. Where necessary, measures had been taken to help reduce risk to people such as the introduction of bed rails, sensor mats and increased observations.
- The home had an effective system in place to ensure the premises and equipment were safe and fit for purpose. A log was used to detail each area or equipment which required checking which contained the date it was last checked / inspected and date of expiry. We found Safety certificates were in place and up to date for gas and electricity, water safety. hoists, the lift and fire equipment, which had all been serviced as per guidance with records evidencing this. Call points, emergency lighting, fire doors and fire extinguishers were all checked regularly to ensure they were in working order. There was an up to date fire risk assessment in place, along with personal emergency evacuation plans.

Staffing and recruitment:
● Sufficient staff had been deployed to meet people's needs.
● Staffing levels were based on people's needs and levels of dependency. Regular reviews of people's needs and level of support they required had been completed and staffing allocated accordingly.
● Staff we spoke with told us although they were busy, current staffing levels were enough for the current occupancy level. Comments included, "At this time it's okay", "We have enough to keep people safe" and "Staffing is fine for the amount of people we have, should this go up, we would need more." The registered manager agreed with this and told us staff numbers would be looked at should the occupancy levels rise.
● Safe recruitment procedures were in place, to ensure staff employed were suitable for the role and people were kept safe. Personnel files contained references, proof of identification, full work histories and Disclosure and Baring Service (DBS) checks. DBS checks help employers make safe recruitment decisions as they identify if a person has had any criminal convictions or cautions.

Using medicines safely:
● Medicines were being managed safely by staff who had received training and had their competency assessed at least annually.
● Each person had information on file which clearly detailed each medication they took, what it looked like, dosage information and administration times. A summary sheet had been attached to each Medicine Administration Record (MAR) which provided information on medical issues, allergies and support the person required with medication. This ensured medicines were administered safely, at the right time and how the person wanted them.
● MAR charts had been completed accurately and consistently. A colour coding system had been used to distinguish the different administration periods e.g. morning, lunch, tea and night time.
● Stock checks of medicines showed the amount remaining tallied with the amount received and what had been administered. This confirmed people had received their medicines each day as prescribed.
● We saw 'as required' (PRN) protocols in place for people who took this type of medicine, such as paracetamol. These provided staff with information about how much to give, when to administer and what signs to look for that would indicate the medicine may be required, in case the person couldn't tell them.
● Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We found these medicines had been administered and documented as per guidance.

Preventing and controlling infection:
● The home had effective infection control policies and procedures in place. The home had recently been awarded a five-star rating, the highest achievable, for infection prevention and control by Wigan Council.
● Bathrooms and toilets contained hand washing guidance, along with liquid soap and paper towels. Staff had access to and used personal protective equipment (PPE) such as gloves and aprons, to minimise the spread of infection.

Learning lessons when things go wrong:
● Evidence was available to show that when something had gone wrong the registered manager responded appropriately and used any incidents as a learning opportunity. Action plans to reduce the likelihood of a recurrence had been introduced and completed.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

People's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance:
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 Act 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- The home used a log to record all DoLS applications, which included the type of application, date of submission, whether authorised, date of expiry and any conditions attached to the DoLS.
- Application forms, authorisations and any other related correspondence had been stored in a designated DoLS file for easy reference. We saw evidence of applications being chased up periodically when there had been a delay in the local authority completing the necessary assessments.
- People's care files contained records of any restrictive practices, such as the use of bed rails and bumpers to keep people safe. We saw best interest decision making had taken place to ensure the measures used where the least restrictive method possible and in the person's best interest.
- Care files contained consent forms, which people had signed to agree to the care plans in place and that these met their needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
- People's likes, dislikes and preferences had been captured as part of the admission process. These had been reviewed monthly and updated to reflect any changes.
- Prior to people moving in, pre-admission assessments had been completed. These ensured the home could meet people's care needs and the environment was suitable.
- Each person we spoke with, told us they were happy with the care they received and were supported to make choices each day.

Staff support: induction, training, skills and experience
- Overall staff spoke positively about the training provided, telling us enough was provided and they were monitored to ensure they completed scheduled sessions and remained up to date. However, the home used

a lot of e-learning, which some staff felt was not as engaging as face to face sessions.
● Upon commencing employment staff completed a three-day induction process which included completion of training sessions the provider considered mandatory, such as safeguarding and manual handling. Staff also worked alongside experienced staff to help gain practical knowledge of the people living at the home and how they wished to be cared for.
● Staff all confirmed they received supervision, although we received differing accounts regarding the frequency of these. Comments included, "Yes, we have supervision, though not sure how often", "We have supervision quite often, they regularly ask you what you are doing and if you have any concerns" and "Yes, we have supervision about twice a year."
● Company policy indicated staff would receive supervision twice a year, as well as an annual appraisal. Records in staff personnel files, showed this had been achieved.
● All the people we spoke with felt staff were knowledgeable and well trained. Comments included, "The staff are good at everything they do" and "The staff are all tip top".

Supporting people to eat and drink enough to maintain a balanced diet:
● People and their relatives we spoke with were complimentary about the food provided and confirmed they received enough to eat and drink.
● Comments included, "I have no complaints about the food. If I don't like something, they will always make me something else" and "I get plenty to eat and drink. They will give me food and drink in my room if I wish. There is always a choice and they will make something completely different if you ask".
● The home met people's specific dietary requirements, for example those who required a soft or pureed diet, or thickened fluids, with detailed guidance available in care files and in the kitchen. During inspection we saw people received food and drink in line with this guidance.
● The home monitored people's weight with the frequency being determined by the nutritional screening tool in use.

Staff working with other agencies to provide consistent, effective, timely care:
● Where concerns had been noted, such as unplanned weight loss, issues with swallowing or issues with skin integrity, we saw timely referrals had been made to professionals such as GP's, dieticians, district nurses and speech and language therapists (SaLT). This ensured people received the correct care and support.
● Guidance from professionals was included in people's care files and helped inform both risk assessments and the care planning process.

Adapting service, design, decoration to meet people's needs:
● The environment within the home had been adapted to meet the needs of people who lived there. The communal areas were brightly painted, with contrasting coloured handrails, which helped ensure these could be identified.
● Pictorial signage was available within communal areas, bathrooms and toilets throughout the home, to help people locate and identify these.
● People's bedroom doors contained a number and a picture frame in which was the residents name, a photograph and a picture of something relevant to them. This helped to personalise the door and make it recognisable to the person.
● Within each lounge was an orientation board, which listed the day, date and weather.

Supporting people to live healthier lives, access healthcare services and support
●People had access to a range of medical and healthcare services, with support to make and attend appointments provided by the home.
● Professionals, including GP's, district nurses, podiatrists and opticians regularly visited the home to meet

people's medical needs. Advice and guidance had been clearly captured and implemented into people's care plans.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:
● People and their relatives spoke positively about the standard of care provided. Comments included, "They are wonderful they can't do enough and they talk with me whenever they come in", "The staff are very kind. They work extremely hard and try to please me all the time. They will sit and chat and we have a laugh" and "The staff are very kind, caring and respectful and I have no worries about [relative] when I leave and go home. I have complete piece of mind that she is well looked after."
● We found people to be clean and well groomed. Staff documented all personal care support provided and we saw people had been supported to wash, bathe or shower, in line with their wishes.
● Observations during inspection showed staff were polite and friendly with people, with appropriate use of physical contact used to help reassure people. People were comfortable in staff's presence and we saw lots of smiling and laughter throughout both days.
● There was a positive culture at the service and people were provided with care that was sensitive to their needs and non-discriminatory. Care files contained sections to document whether people had any specific needs, whether these be spiritual or cultural.
● At the time of inspection nobody living at the home had any specific requirements, however staff told us these would be catered for.

Respecting and promoting people's privacy, dignity and independence:
● Staff were mindful about the importance of maintaining people privacy and dignity and ensured this was done consistently. Comments from people and relatives we spoke with included, "The staff always knock on the door before they enter the room and they shut the door if something private is going on", "They do little things that demonstrate they show respect, such as covering Mum's legs if her blanket falls off" and "They demonstrate that they care for Mum very professionally. They respect her by never shouting out that she needs the toilet so anyone else can hear. They never walk in her room and just pull back the blankets to check her, they always tell her what they are doing."
● People also told us staff promoted their independence by letting them do what they can for themselves. One told us, "The staff do encourage me to be as independent as I can. For example, when I am being washed, they will let me wash my top half which I can do."
● During the inspection we observed a person at lunchtime being encouraged to feed themselves. The staff member provided support when they saw the person was having difficulties, however also encouraged them to have another go at using their spoon to feed themselves.

Supporting people to express their views and be involved in making decisions about their care:
● People received care in line with their wishes from staff who knew people well and what they wanted.

● Not all the people we spoke with could remember going through their care plan, however one person told us, "I know what is in my care plan and how I am to be cared for. I am very happy with everything."
● Relatives also told us they were involved in making decisions about the care of their loved ones. Comments included, "They keep in contact at all times. In fact, they called me this morning as Mum isn't too good today" and "They will call me if Mum isn't well. The other day she wasn't right and we agreed that they would test for an infection. When appointments come through for her, they let me know straight away."
● Resident meetings had been held quarterly, to provide people with a forum to raise questions or queries and also receive information about the home, upcoming plans and events.
● Information was also provided by way of monthly newsletters, posters and booklets which had been displayed on notice boards throughout the home.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
● People received care which was personalised and met their needs and wishes.
● Care files contained a range of person centred information, which provided staff with details of people's background, family life, work history, likes and dislikes. People we spoke with told us staff knew them well and what was important, one stated, "The staff know me very well. They know my interests and my hobbies. They know I like to go to the pictures and they have arranged trips out for me to see films I like to see. They know I like to watch films on TV sometimes till very late at night and they let me do that. The staff know I like to have a sandwich about 10 p.m. at night. They make some for me every day."
● Upon admission people had been asked whether they would like to be involved in the care planning process, handle their own monies, manage their medicines as well as decide how they wanted their room to be set up. People were also asked if they would like their relatives to be involved in their care. This ensured they were at the centre of decisions making about their care.
● The home ensured people had access to the information they needed in a way they could understand it and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.
● People had communication care plans in place which explained any difficulties they may have and how best to communicate with them.
● The home used electronic devices to communicate with people who had impaired verbal communication skills. Easy read guides relating to MCA, DoLS and safeguarding had been sourced and where on display.
● People's access to activities had been affected by the activity coordinator leaving at short notice and the lack of success in recruiting a replacement. We saw alternative plans had been put in place, with one of the healthcare assistants taking over the role alongside their other duties. They were being supported by the provider's activity maintenance manager.
● At the current time, people took part in activities at least twice per week, with records kept of participation. During December 2018, we saw activities had included a carol concert by children from a local school, making Christmas cards and decorations and a Christmas party with an entertainer, which people we chatted with spoke positively about.
● The registered manager confirmed recruitment to the activity post was ongoing and once filled they hoped to get back to offering a range of daily activities.

Improving care quality in response to complaints or concerns:
● The complaints procedure was displayed clearly within the home and both people and relatives we spoke with where aware of what to do should they have any concerns.
● Only one person we spoke with had raised a concern. They had spoken with the registered manager, who had informed them of the action that would be taken to address their concern. The person was satisfied

with the response received.
● The home used a log to record any complaints received. Only two had been received since the last inspection. We found descriptions of the concerns had been recorded along with details of action taken and outcomes.

End of life care and support:
● People who wished to, had been supported to make decisions about their preferences for end of life care, which were clearly detailed in the relevant section of their care plan.
● Where people's health and presentation was deteriorating, the home had liaised closely with GP's regarding statements of intent. We saw these were in place and had been renewed within agreed timescales.
● Nursing staff had received training in end of life care and the use of necessary equipment such as a syringe driver, which is used to administer medication at a constant rate through a small needle placed under the skin. The deputy manager was qualified to provide training in the use of a syringe driver. We were told only agency nurses who had received training could work at the home, to ensure consistency of care.
● Staff understood people's needs, were aware of good practice and respected people's religious beliefs and preferences at this time of their life.

Good

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 in November 2017, this key question was rated as 'Requires Improvement'. This was because we had identified a breach of the regulations within the safe domain and as a result, the well-led key question could not be rated higher than requires improvement. At this inspection we found the provider was meeting all of the regulations.

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

- The home had a clear management structure, with the registered manager being supported by a deputy manager. Both had worked at the home for many years and knew people and the staff well.
- Staff told us they felt the home was well run and felt supported in their roles. Comments included, "[Registered manager] is brilliant with me, not a bad word to say about them or [deputy manager]. If worried about anything, they will listen", "I love it here, the managers are definitely very approachable" and "I like it here much better than other homes I have worked at. The managers are very good and were very supportive of me when I started."
- The registered manager understood their regulatory requirements. The previous inspection report was displayed and available within the home and on the providers website. The registered manager had submitted relevant statutory notifications to CQC, to inform us of things such as accidents, incidents, safeguarding's and deaths.

Continuous learning and improving care; planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:

- All adult social care providers are required to have a statement of purpose (SoP). The home had an appropriate statement of purpose, which set out the aims, objectives and ethos of the service.
- A number of audits and quality monitoring had been completed following an annual schedule. This detailed each area to be audited and the frequency. Areas covered included; health and safety, incidents, medication, care documentation, and pressure care.
- For each audit completed we saw separate documentation had been generated which contained any action points and outcomes.
- Since the last inspection, a provider level audit had been completed each month, to ensure greater oversight of service provision had been maintained. The provider had plans to introduce further internal quality monitoring processes, such as a daily walk round by management, when key areas would be assessed and documented.
- The registered manager and provider were aware of their responsibility regarding duty of candour. Duty of candour ensures providers are open and transparent with people who use services and other 'relevant

persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

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

● There was a positive culture at the home. All staff spoken with told us they enjoyed their jobs and that effective team working helped ensure people received good quality care.

● Staff meetings had been held, however staff's understanding of the frequency of meetings varied. The majority told us these were held every one to two months, whereas one stated they were twice a year. From looking at the meetings file, we saw four meetings had been held in the last four months, which included two full team meetings, a meeting for just night staff and one for nurses and healthcare assistants.

● We found the home to be an inclusive and empowering environment. The views of people, relatives and staff were sought and they were also involved in making decisions about how the home was run. Annual questionnaires had been distributed to people and their relatives. At the time of inspection, the analysis had only just been completed. We were told the results of the survey and any action points would be subsequently shared with people through meetings and by posting information on the notice boards.

● We noted a number of examples of the home working in partnership with other professionals or organisations. The deputy manager had signed up to be a dementia friend, which is an initiative run by the Alzheimer's Society. The home had links with a local school, with children visiting the home to engage in activities. The registered manager told us they wanted to strengthen this link and have the children visit more often. The home had also approached the council in Angers, France, a town with whom Wigan is twinned, to look into the possibility of Haighfield being twinned with a home in Angers. This was to enable the communication and sharing of ideas and forge links and relationships between people living in both homes.