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Haighfield Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Haighfield Care Home on 27 November 2017.

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.

Haighfield Care Home is a purpose built, four storey home located in Standish, Wigan. Haighfield Care Home can accommodate a maximum of 45 people. The care home has 39 bedrooms; 14 bedrooms have en-suite facilities and there are four companion rooms. Haighfield Care Home offers residential, nursing, continuing care, day care and respite care services. At the time of the inspection there were 28 people living at the home.

The home was last inspected on 27 June 2016 when we rated the home as requires improvement overall and identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to safe care and treatment and good governance. We also made a recommendation regarding the environment. At this inspection we found the registered manager had addressed our concerns and was now compliant with these regulations.

However, during this inspection we identified one breach of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regards to protecting service users from abuse and improper treatment. You can see what action we told the provider to take at the end of the full version of this report.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission 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.

People, relatives and visitors told us Haighfield Care Home was a safe place to live. We saw comprehensive risk assessments in place and care plans had been developed taking in to account people's wishes and preferences.

We found systems required strengthening regarding both the identification of safeguarding concerns and reporting procedures to the local authority. We acknowledged the registered manager had put in measures to address the concerns and there had been a misinterpretation of the local protocols. Management informed us they would attend the local authority safeguarding training to address this deficit in knowledge and understanding.

We received mixed views on whether there was enough staff on duty to meet people's needs. At the time of the inspection, a dependency tool was not used to determine care hours needed to meet people's needs.

However, following the inspection, the registered manager introduced this and told us it had deemed there was sufficient staff deployed at the time of inspection.

Medicines were managed safely but we found discrepancies with the administration and recording of creams. This had been identified on an internal audit prior to our inspection and the deputy manager was in the process of addressing this with staff at the time of our inspection.

There was an appropriate recruitment process in place. Steps were taken to verify new employee's character and fitness to work. Following successful appointment to the role, the provider ensured staff received an induction and this was in the process of being aligned with the care certificate.

Staff expressed feeling supported by management. We saw staff developed and maintained their skills and knowledge through ongoing support and regular training. The staff liaised with a range of health care professionals to ensure that care and support to people was well coordinated and appropriate.

All staff spoken with demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider had submitted applications were required and had an effective system in place for monitoring and tracking applications.

We saw the mealtime experience was positive, people's dietary needs were met and people were complimentary of the food choices and quality of the food provided.

During the inspection we noted positive staff interaction and engagement with people using the service. Staff addressed people in a respectful and caring manner and the home had a calm and warm atmosphere. We observed people enjoying each other's company, conversing and laughing with each other.

We saw people visiting throughout our inspection. Visitors told us they were always welcomed and said that communication from the staff and management was good.

People spoke highly of their experiences and that they wouldn't hesitate to recommend the home to other people that were considering a care home.

People had care plans relating to end of life care in their files. People's wishes in relation to end of life care had been recorded where they had been willing and able to discuss this aspect of care provision. We saw families had also been consulted in relation to end of life care.

The management had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a daily, weekly and monthly basis and covered a wide range of areas including medication, care files, infection control, health needs and the overall provision of care. We saw evidence of action being taken to address any issues found.

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 consistently safe.

The system to manage safeguarding was ineffective as we found safeguarding concerns that had not been sent to the local authority in line with local procedures.

The service did not have appropriate arrangements in place to manage the application of people's cream.

People, relatives and visitors told us Haighfield Care Home was a safe place to live.

Is the service effective?

Good

The service was effective

Staff had access to appropriate training to support them in their role. Supervision was conducted regularly and staff received an annual appraisal of their work.

The service was working within the requirements of the Mental Capacity Act (2005) and staff sought people's consent before undertaking care tasks.

Referrals were made to other health professionals timely and the nurses worked closely with other agencies to meet people's health needs.

Is the service caring?

Good

The service was caring

The people we spoke with were complimentary of the care received and spoke highly of the staff.

Staff spoken with had a good understanding of how to maintain people's dignity and respected people's rights.

We observed positive interactions, appropriate physical contact and comfort offered by staff to people living at the home.

Is the service responsive?

Good

The service was responsive.

Assessments of people's needs were completed and care plans provided staff with the necessary information to help them support people in a person centred way.

The home had an activities programme in place. People we spoke with were positive about the activities and events provided.

The home had an effective complaints procedure in place, with all complaints being investigated and outcomes documented.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

The provider was not meeting regulatory requirements as safeguarding referrals had not been sent to the local authority or CQC.

The management were visible to people living at the home and staff. We received positive feedback about their leadership and support from staff and people who told us they would recommend the home to others.

Feedback was encouraged through residents meeting and regular audits. There was also a comment/suggestions box available for visitors/ relative's comments in the entrance foyer.

Haighfield Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is 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.

Our inspection visit at Haighfield Care Home on 27 November 2017 was unannounced.

The inspection team was made up of two adult social care inspectors from the Care Quality Commission (CQC), a medicines inspector from CQC and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience in caring for older people and people living with dementia.

Before the inspection we reviewed the information we held about the service, which included correspondence we had received and any notifications submitted to us by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place; for example, where a person who uses the service has a serious injury.

We also spoke with the local authority quality performance officers, safeguarding, environmental health and infection control to ascertain if they had information to support our inspection planning.

During the inspection we spoke with two people who lived at Haighfield Care Home, five relatives/visitors and one health professional. We spoke with the regional manager, registered manager, deputy manager, three care staff and a staff nurse. We spent time looking through written records, which included five people's care records, five staff personnel files, 10 medication administration records (MAR) and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

During the inspection we asked people if they felt safe living at the home and visitors to the home whether they had any concerns regarding people's safety at Haighfield Care Home. Without exception, all the people and visitors we spoke with told us the home was a safe place to live. Comments from people included; "I feel very safe as there are always lots of people around to look after me. The girls are really good and my belongings are safe too." "I feel safe because I can ring the bell and someone will come to see me." Relatives said; "I visit regularly and I can see the staff do their best for every resident." "[My relative] can't do anything for themselves and so they do everything for them. They are marvellous." "I have no concerns. [My relative] is always fine and they look very happy, much happier than in the last care home they were in." "Overall I think [my relative is safe. They have fallen several times whilst here. They forget to use the buzzer and try to be independent, that is when they fall. They have given them an alert mat now." "I am very happy that [my relative] is safe here. They get all the support they need. I don't have any worries at all. They like a cigarette now and then and the staff will take them outside and back to their room."

A staff member told us; "I know residents are safe. I can go home and sleep."

We looked at the home's safeguarding systems and procedures. The home had a dedicated safeguarding file which contained details and information about any safeguarding incidents which had occurred at the home. The services safeguarding policy highlighted why safeguarding people was necessary and highlighted the principles, key definitions of the term and the services statement of responsibility within the process. We looked at the system in place to safeguard people from abuse and improper treatment and identified shortfalls with regards to the identification of safeguarding incidents and reporting procedures.

We cross referenced the incident and accident documentation with safeguarding referrals made. We noted several instances where the registered manager had failed to inform the local authorities safeguarding team of incidences of people having bruising and skin tears of unknown cause, as well as a medicines error that had occurred. We were unable to quantify the number of people that had been affected because the information had not been individually recorded and was captured in a collective entry.

The deputy manager told us staff had commenced completing body maps when undertaking personal care tasks which had been effective in reducing the number of unexplained bruises and skin tears. It was evident from speaking to the deputy manager the registered manager had misinterpreted local authority reporting procedures. The registered manager had captured the incidents as a tier 1 safeguarding which would require the information to be recorded and the quality performance officers would review this information when undertaking visits to the home. However, as actual harm had occurred and there were multiple instances of harm, the issues were potentially a tier 2 or 3 safeguarding referral and required reporting to the local authority for monitoring. CQC would also have required notification of these events for our intelligence which had also not occurred. Following the inspection, we were informed the registered manager and deputy manager would access training delivered by the local authority to ensure they fully understood the local authority process.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because systems and processes in place to protect people from abuse and improper treatment were not operated effectively.

At our previous inspection in June 2016 we found a breach of regulation in relation to the management of medicines in the home. This was because thickeners were not kept safely and we saw examples of poor medicines stock control. At this inspection, we found that medicines including controlled drugs (which are subject to the misuse of drugs legislation) were stored safely. Adequate medicines stocks were maintained to allow continuity of treatment. The manager completed regular medicines audits in order that any shortfalls identified could be appropriately investigated and learning shared to reduce the risk of reoccurrence. The home had a written policy to provide guidance about the safe handling of medicines in the home but in places this did not refer to the most up-to-date best practice guidance.

We looked at how medicines were managed, which included checking the Medicine Administration Record (MAR) charts for ten people. The medicines charts were up-to-date and clearly presented to show the treatment people had received. Protocols were in place proving guidance for staff about the use of "when required" medicines but these could be further individualised. Where new medicines were prescribed these were promptly started.

However, the records for the application of prescribed creams were less clear. Care staff applied creams as part of personal care. Carers signed when they had applied a cream and the nurses' made an additional record on the medicines chart. We found that these records did not always match, making it impossible to tell when the cream was actually used. We also found that one person had two creams in their room that were not listed on their administration records and a second person had a cream originally prescribed for a different person in their room. We noted this issue had been identified on the deputy manager's audit the previous day and a meeting had been arranged to address this with staff. We will follow this up at our next inspection to ensure procedures have been implemented to prevent re-occurrence.

We observed nurses administering people's medicines. Arrangements were in place to ensure that special instructions such as 'before food' where followed and care was taken to ensure that Parkinson's medicines were given on time so that people received the most benefit from them. People who chose to and were able to self-administer medication were supported to do so. Where people lacked capacity to make decisions about their medicines, appropriate safeguards were in place to ensure that people's best interests were protected. 'Home remedies' were kept to support the prompt treatment of minor ailments.

We looked at how the registered manager determined staffing levels and the deployment of staff. We looked at staff rotas for the previous four weeks including the week of inspection. At the time of inspection, there were five care staff on duty, three care staff to cover the upper floors and two care staff downstairs. There were also two nursing staff on duty, domestic and kitchen staff. We received mixed views from people, relatives and staff as to whether there were sufficient numbers of staff deployed to meet people's needs. People said; "There are just enough staff. I always say we could have just one more on each floor. When I ring the bell they do come, but the speed at which they come depends on how busy they are." "There are plenty of carers they come to help me fairly quickly, but if they are busy I have to wait a little longer. They do get agency staff to help out when they are short." All the relatives said the permanent staff work very hard, but felt more staff were needed. "They work very hard, they are very attentive, but I think there could be more as they don't stop working." "I don't think there are always enough staff. The agency workers are not as good as the permanent staff, they are smashing. They do have agency workers fairly regularly." "About a year ago I did raise a concern that there were not enough staff. I felt there were less staff at the weekend, but I feel things are a little better now." "On the whole I think there are enough. They seem to get to [my relative]

very quickly when they call for them." Staff also told us they felt they would benefit from more staff as people's needs had increased and there was a high number of people requiring two to one care.

At the time of inspection, we noted the registered manager did not use a dependency tool to determine staffing levels across the service, therefore could not evidence that the correct amount of staff were deployed to each floor. Following the inspection, the registered manager told us a dependency tool had been used to calculate staffing hours. We were told this showed at the time of inspection there had been sufficient staff deployed, as per the calculated hours determined by the dependency tool. This will be followed up at our next inspection. At the time of inspection, we observed there was a staff presence in each lounge to respond timely to people's needs throughout the day and call bells were answered promptly.

We observed all rooms had a call bell next to the bed and some people had pressure mats when identified as a falls risk or requiring support when out of bed. A nurse call bell risk assessment was completed and for those people unable to use the call bell, staff completed hourly checks. People confirmed the call bell was always in reach. People said; "The bell is always within reach and if they forget to give it to me when they put me in my chair, I make sure they rectify the situation." "I have a bell which has a very long cable. It can reach anywhere in the room."

We saw in all the files we looked at that the home had completed comprehensive risk assessments, which had been reviewed regularly for each person. Risk assessments viewed covered; ; moving and handling, falls, malnutrition, eating, drinking and swallowing, continence, pressure ulcers and use of bed rails. We saw comprehensive dysphagia information captured when a person was identified as having swallowing difficulties. This included a list of foods the person was unable to have due to the risks, such as beans and peas..

The provider had recruitment procedures designed to protect all people who used the service and ensured staff had the necessary skills and experience to meet people's needs. We looked at five staff personnel files in total. We found recruitment checks had been completed before new staff commenced working at the home. Files included proof of identity, equal opportunities monitoring documents, employment and character references and a Disclosure and Barring Service (DBS) check. A DBS is undertaken to determine that staff are of suitable character to work with vulnerable people.

In addition to this we saw that qualified nurses who worked at the home were maintaining their registration with the Nursing Midwifery Council (NMC) and their personal identification numbers (PIN) were in date. These checks would ensure staff remained suitable to work with vulnerable adults. A nurse validation monitoring form was kept in the main office and was reviewed each week to ensure compliance with this requirement was met.

The service ensured contractual arrangements were in place for staff and we saw evidence of this in the five staff files. Disciplinary procedures were also in place to support the organisation in taking immediate action against staff in the event of any misconduct or failure to follow company policies and procedures.

We spent time walking around the building looking at communal rooms. The environment was clean and free of malodour. We noted equipment was stored appropriately and the stair well situated in the reception area was free from clutter.

We saw toilets and bathrooms were clean, tidy and contained appropriate hand hygiene guidance. We also looked in several bedrooms and found these to be clean and tidy. The home employed domestic staff and we saw them undertaking their work throughout the day of the inspection. We also saw staff wore

appropriate Personal Protective Equipment (PPE) when assisting people with personal care and when assisting people to eat their food at meal times. This would help reduce the spread of infections.

Environmental risk assessments were in place to maintain a safe environment and ensure the protection of people using the service, their visitors and staff from injury. Risk assessments gave consideration to areas such as the internal and external environment, storage of controlled substances (COSHH), stairs and lift, gas and electrical safety. Equipment such as kitchen and bathroom aids were also examined by an external agency and were serviced in line with manufacturing recommendations. A maintenance person was employed to ensure any maintenance issues were resolved within an acceptable time scale. External contractors were also used when necessary to undertake the servicing of areas which were not assessed as the maintenance person's area of expertise.

Fire procedures were in place and each person had a personal emergency evacuation plan (PEEP). PEEP's considered areas such as level of mobility, responsiveness to an alarm and prescribed medication. We noted a 'grab file' was kept in an area which was easily accessible to the emergency services should they be required to respond, this contained the correct amount of information relating to each person using the service. Fire risk assessments were evident along with a record of fire systems, emergency lighting and fire alarm checks. Contingency plans were also in place detailing steps to follow in the event of emergencies and failures of utility services and equipment.

Good

Is the service effective?

Our findings

We asked people living at the home whether the staff had the required skills, knowledge and understanding of their need. Everyone we spoke with felt the staff were well trained. People said; "They look after me very well. The carers are marvellous people they have to use the hoist to move me and they know how to do that very well." "The carers are very good they know exactly how to care for me and I have never felt there is anything they can't do for me."

We looked at the training staff received upon commencing employment at the home. There was an induction programme in place which staff completed when they first commenced work at the service. The induction required staff to attend a three day event held within the service. This provided an overview of their job role and the requirements of working in a care setting along with training in fire procedures, definitions of abuse, moving and handling, equality and diversity, infection control and catheter care. The induction covered the standards of the care certificate. Staff we spoke with confirmed they received a thorough induction on commencing employment. A staff member said; "The induction was good, I was shown everything before I was included in the numbers."

The regional manager advised us the care certificate was being introduced in to the home which new staff would be required to complete. The care certificate assesses the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care. It is awarded to care staff when they demonstrate that they meet the 15 care certificate standards which include; caring with privacy and dignity, awareness of mental health, safeguarding, communication and infection control.

The provider commissioned a number of training courses from Social Care TV which is an accredited e-learning system for health and social care providers. The staff were required to complete the training module and then staff completed workbooks to determine their competency. Staff had completed training in areas such as fire safety, safeguarding, moving and handling, health and safety, infection control, COSHH, food hygiene, medication, mental capacity and equality and diversity. Staff told us; "We complete a lot of training and watch DVD's downstairs. We complete questionnaires which the management have to sign off. Training I've completed includes; fire, abuse, food hygiene, MCA, dementia, nutrition, moving and handling. I feel we get more than enough training." "We watch DVD's and complete an assessment. I would like mattress training." "Training is under review which will hopefully mean more face to face training."

Staff received supervision as part of their on-going development and support. We reviewed a sample of these during the inspection and saw topics of conversation included, training requirements, safeguarding, mental capacity subjects, building security and night routines. Staff told us they received supervision and felt it was a positive experience and provided one to one time to discuss any concerns they may have.

We found staff were knowledgeable regarding people's dietary requirements and they were able to tell us who required assistance or had specialist dietary needs. We saw a current resident's nutritional requirements list was in place dated November 2017, which was reflective of people's current dietary needs.

We observed the breakfast, lunch and evening meal during the inspection. In each dining room there was a small menu which identified the meal. Staff read out the menu to people so they were able to make their own meal choices.

Each dining area had several tables which were set with tablecloth, place mats, knives, forks, napkins and flowers. The food was brought up to each dining area on a hot trolley, this included the soft and pureed meals, which meant people requiring a modified diet had the same choice of meal as everyone else. As the meals came on a hot plate, people were asked what size portion they would like and whether they wanted seconds. On the day of inspection, lunch was chicken curry, casserole, or sausage chips and broccoli. It was apple crumble and ice cream for desert. People were offered a bowl or plate for their meal and asked the portion size they wanted.

Each person's food that had been prepared for them was appropriate to their needs. Both hot and cold drinks were offered throughout the meal. Thickener was added to drinks when necessary. The meals were relaxed and not rushed. People who could feed themselves were encouraged to do so and help offered only when needed. People that required assistance, were supported one person at a time. We observed one person was supported with their meal and upon completion of the meal, was left with soft finger foods to eat independently whilst the staff member went to support another person. It was noted that everybody was eating at the same time and were not having to wait for support.

All the people spoken with during the inspection said the food was good; there was plenty to eat and a good choice. They informed us that if they didn't like a meal they could ask for anything and it would be made for them. All said they got plenty of drinks throughout the day and in the evening until bedtime. People said; "The food is quite nice and there is a choice. I'm never hungry as I get plenty. If I want a drink they will make one for me." "I like the food, but some days it is better than others. There is always a choice. I have my own snacks and if I ask for sandwiches or toast in the evening they will make them for me."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and found conditions on authorisations to deprive a person of their liberty were being met. The manager maintained a DoLS matrix which identified when an application had been made, granted and
expired. We saw MCA/DoLS information was stored in people's care plans, including when an authorisation had been submitted.

We asked staff about their understanding of the MCA and DoLS. All staff confirmed they had received training and had an understanding of both. One staff member told us; "We have a little booklet we carry and refer to regarding mental capacity. Capacity relates to people's ability to make their own decisions. We would need a DoLS if a person needed to be here but wanted to go home."

We saw people's capacity to consent had been captured and best interest meetings held when people were

not deemed to have capacity to make a specific decision. A record of restrictive practices in place had been maintained, such as for the use of bed rails, a bucket chair that had been put in place following a person continuing to slip from chair, covert medicines and locked doors. We saw a best interest meeting had taken place because a person was refusing their personal care needs. We saw records of the meeting were maintained, including who had been involved in the discussion and all agreed decisions. These records were stored in people's care files and incorporated in to care plans.

All the people and visitors we spoke with said the staff always sought their consent. People said; "They always knock on my door and ask permission to come in." "They will always ask my permission before they come in my room or before they move me." Relatives told us; "They are very polite and always tell [my relative] what they are doing. I know they do the best for them at all times." "They always get my husband's consent before they do anything."

We saw the home worked closely with other professionals and agencies to meet people's health needs. Involvement with these services was recorded in people's files and included general practitioners (GP), chiropodists, district nurses, dieticians and speech and language therapists (SaLT). Health professional visits were captured on the specialist visit record which identified the reason and outcome of the visit.

At this inspection, we looked specifically at the documentation and management of pressure care for people identified as being at very high risk of skin breakdown if not managed effectively. We found Waterlow risk assessments had been completed and up to date care plans were in place for the management of pressure areas. We confirmed pressure relief was being provided within the necessary timeframes and saw the required equipment was in use. Staff had identified the fluid amounts people required to maintain good skin integrity and we observed fluids being provided throughout the inspection to achieve this.

We saw bedroom doors contained plaques onto which people's pictures or pictures of interest and meaning to the person had been attached. There were also information boards on display that informed people living at the home of the date, season and current weather. Communal bathroom and toilets were clearly identified by large signage written in clear text. However, signage around the home was not wheel chair friendly and required consideration to ensure everybody's needs were catered for.

Good

Is the service caring?

Our findings

Everyone we spoke with during the inspection said the staff were very kind and caring and could not do enough for people. People said; "They are very kind, they wash me and they will help me out with anything if I ask for help. They are wonderful." "They are wonderful, they can't do enough and they talk with me whenever they come in." Relatives said; 'Oh yes definitely. They are very caring at all times. The staff are so patient." "I have watched the staff moving and handling [my relative] to get them up out of their chair. At all times have I seen them demonstrating kindness and compassion. They demonstrate empathy for their needs." "Yes, at all times the staff show kindness. [My relative] can have a laugh with them. They have a good rapport with the staff."

A healthcare professional also told us; "All the staff are very good. The staff are caring and lovely people. They can't do enough for you."

Everyone interviewed commented highly on the standard of care and the quality of the staff working at Haighfield Care Home. Everyone spoken with said the home was a friendly, caring and warm environment and all the relatives and visitors to the home said they would recommend the home to others.

During our visit, we observed staff supporting and interacting with people in an appropriate manner. People were referred to by name and there was banter and laughing heard between people and staff. We observed staff knocking on bedroom doors before entering and witnessed staff explaining to people what they were doing before undertaking care tasks to avoid causing distress or upset.

Throughout our visit, we noted staff were very polite and friendly with people and they were keen to help people as much as they could. We saw one staff member needed to wake a person to support them with their meal. The staff member did this with kindness and gently called their name and stroked their hand. The staff member asked them if they were hungry and whether they would like some lunch. The staff member noticed that the person's eye was weeping so she explained to them that she was going to get a wipe to clean their eyes so that they were more comfortable. The staff member returned and wiped their eyes and then proceeded to support them with the meal.

We observed some bedroom doors were left wide open all day but when we asked the person they told us this was their choice so they could see people go past their bedroom.

People told us staff respected their dignity and privacy. People said; "Yes they are very respectful. They knock before they enter my room. When they wash me, they cover me up with towels until I am in the water in the shower." "They treat me with the greatest of respect."

Relatives were in agreement, although one relative informed us of an incident they had discussed with the manager that had been resolved. They said; "Yes they demonstrate respect. I have had worries regarding dignity as I have raised concerns in the past that they have dressed [my relative] in very short pants and on one occasion a lady's trousers. That did nothing for his dignity. It was sorted out after talking to the

manager." Other comments made included;; "The staff are fantastic, I cannot find fault them. " "[My relative] can do nothing at all, so the carers have to do everything for them. They are very good with them and sympathetic to their needs." "They always knock on the door before they enter the room and they shut the door if something private is going on." Staff told us; "We do everything discreetly. Close doors, ask discreetly."

We looked to see how staff promoted people's independence and offered them choices. People told us without being asked that the staff were very patient. People's comments included; "They never rush me, they let me go at my own pace." "They never rush me when I am trying to walk. When I'm in the hoist they move me slowly so I am comfortable." "I am confident in the staff's ability. I have to try to keep walking. At first, I was nervous, but now I am confident that they won't let me fall. They never rush me they tell me to take as long as I need." Staff told us; "We get people to always do what they can for themselves."

Everyone stated their visitors were welcomed and there was no restriction imposed on visiting. . People said; "I can have visitors at any time and they can stay as long as they wish." A relative said; "I am made to feel very welcome, when I come they offer me drinks and sometimes I have eaten my meals here too."

Good

Is the service responsive?

Our findings

Relatives we spoke with told us staff were responsive to their family member's needs. Comments included; "The staff are very aware of their needs and preferences. The staff assist them to get in and out of their chair with the use of a hoist." "They know [my relative's] likes and dislikes. They know the only thing they will have for breakfast is tea and toast." "They know what food [my relative] likes and dislikes. They often talk to them about their family and hobbies."

We saw each person's care file contained a checklist which indicated whether people wanted to be involved in their care plan and whether they wanted their family to be involved. The checklist also included; what furniture items people wanted in their room; how many chairs and if anything needed to be added to their room. People were offered a key to their room and had a risk assessment completed to support this. People's equality and diversity and protected characteristics such as race, sexual orientation and disability were considered at initial assessment and management and staff demonstrated a good understanding of these considerations.

Care plans included; communication, mobility, breathing, diet and eating, personal hygiene, sleep and rest, elimination, social and relaxation, sexuality and self-concept, mental health, condition of skin, maintaining safe environment, nutrition, oral hygiene, tissue viability and medical information. People told us they were aware of their care plan but were happy for the staff to complete them. We saw evidence that discussion with families about care plans had taken place as these had been documented on the communication sheet in each person's care plan.

Relatives told us; "I have seen the care plan, they showed it to me once. I haven't attended any review meetings. "My brother has dealt with the care plan, but I know it is in place. I know they encourage [my relative] to do as much as they can for themselves." "I was involved in planning [my relative's] care when they first came here. I can't remember if I have been to any review meetings. The care they provide does include encouraging them to be as independent as possible, so they encourage him and offer help when needed." "I was involved in the care plan at the start, but I haven't attended any more meetings. He does things for himself whenever he can, so he feeds himself and he can use his wheelchair to get around."

We saw care files captured information about people's life histories and covered family life, working life, things people enjoyed, important people and dates, special thoughts, likes and dislikes. We saw that individual care plans had been included which highlighted any problems or needs, the desired outcome of the person and action points to achieve this.

We saw people's individual needs were met and one person had been supported to complete a smoking cessation programme. Their care plan indicated that they continued to smoke and used e-cigarettes. The person and their relative had indicated they were in agreement that these were removed and that their relative was responsible for charging their e-cigarette at home.

During the inspection, we did not observe any activities being provided, however people and their relatives

spoke of the choice of activities available and the party events that took place. There was also a television monitor playing on a loop displaying photographs of residents taking part in activities. We saw a timetable that listed the activities provided which included; playing games, music therapy, tea parties, pamper days, exercises, reading groups, arts and crafts. Special occasions were also celebrated; there were fireworks on bonfire night and entertainers scheduled for Valentine's Day and Mothering Sunday.

Relative told us; 'Since [my relative] has been here they are more interested in the activities than they have been in other homes they have stayed in. [My relative] is happy here and happy to watch what is going on even if they don't always take part in the activity. They are more stimulated here." "[My relative] doesn't take part in many activities but they do like the bingo. They have attended some of the parties they hold for events such as birthdays, Easter or Christmas." "[My relative] doesn't go to many activities as they maintain their own interests. They will go to the parties they put on, but not the everyday activities."

We asked staff if they thought people had enough to do during the day. Staff told us; "There is an activity person Monday to Friday. People don't always want to join in activities; they will do the music quiz, have nails done, bingo and parachute with a ball. We used to do barge trips but people are now too ill. The provider has sorted a new veranda so people can do some gardening in tubs. I would love to take people out but there are not enough of us." "There's not enough going on for people. It's hard. We could be doing more things. People don't get out. I'd love to take people to the shops, coffee shops, the pub. A lot of the staff would like to be able to take people out. The parties are great and Christmas will be lovely but I wish we could do more." "There is only so much we can do. People are not communicative. We do one to ones and people's nails, shave and hand massage. The vicar from the church used to come in once a week but now not so regularly."

We looked at how complaints were managed. There was a complaints policy and procedure in place which had contact numbers for CQC and the local authority. We noted five complaints had been received since the last inspection in June 2016. The five complaints were relating to low level issues for example, car headlights shining into people's bedrooms. Each of these complaints had been dealt with in line with company policy and positive outcomes had been achieved. In addition to this we saw the service had a file containing compliments received from people using the service and their families. Compliments thanked the staff for all their hard work and caring nature. Staff told us; "We don't get complaints regular."

People's end of life care was dealt with in a sensitive way. When appropriate, and where people had chosen to, documentation was in place to ensure their end of life wishes were considered. This included decisions around resuscitation, which was clearly documented and reviewed by a GP where appropriate. Relatives told us; "End of Life (EoL) plans are in place with the hospital and with the GP. They know [my relatives] wishes and they will contact me immediately if anything happens." "EoL plans are in place. It is [my relatives] wishes that they will provide end of life care in the home and not send them to hospital."

The home had been selected to be involved in the hospice initiative to work alongside an EoL team from Wigan and Leigh Hospice to help improve practices and knowledge in relation to end of life and palliative care. However, we were disappointed to be informed the staff had ceased engaging and the care home had dropped out of the programme within a couple of weeks.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

The home had an established registered manager who had been in post for several years. The registered manager was directly supported by a deputy manager. The management were knowledgeable about people's needs and familiar to people living at the home. This was reflected in the positive feedback we received when we asked people and their relatives whether they would recommend the home to others. Everyone we spoke with said Haighfield Care Home was a good home, which they would recommend to others.. People told us; "I came to live here because [my relative] was here for six years. When they died I booked myself in because I was happy with the home." "I would recommend the home to anyone. In fact, I have told all my family and friends how good the home is and how happy I am."

Similarly people's relative, staff and a visiting health professional only had positives to say about the culture and atmosphere in the home. Relatives told us; "There is a very good atmosphere in the home. The medical staff and general staff never hide anything, they are very open and honest. They always know the needs of the resident if you ask them anything. "The home is a very positive place. They tell you everything, nothing is hidden. It is very easy going and a lovely quiet place." "It has a very positive feeling, very open and honest. They have kept me fully informed when [my relative] had some pressure sores. They changed their dressings nearly every day and it cleared up very quickly." "All the staff are very open. For example, [my relative] fell yesterday. They phoned me straight away to keep me informed." "The home is a lovely place, so calm and supportive. They keep me informed at all times. There is a very positive supportive atmosphere here as I can stay all day if I wish. In fact, when I do they offer me meals too." Staff said; "I know we are a good home. I wouldn't hesitate to have my relative here. "Healthcare professionals said; "From what I've seen, I feel the home is a good home and well-led."

Despite the positive comments provided by people, relatives and staff, this domain cannot be rated higher than requires improvement because we identified a breach of the regulations within the Safe domain. As a result, the well-led key question cannot be rated higher than requires improvement. Similarly, in line with CQC's enforcement policy, the overall rating for a service cannot be better than requires improvement if there is a breach of the regulations.

Staff also told us they enjoyed working at the home and felt supported. Staff said; "I feel very supported by management. The deputy manager is also very good. We have regular team meetings and things run smoothly." "I feel supported. I think team meetings could be more frequent and us speak more about the residents and their care needs." We saw staff meetings were held for both day and night staff. Topics of discussion included recruitment, uniform, policy changes, sickness, fire plans and training topics. The minutes of these meetings were available which we reviewed during the inspection.

We assessed what systems the service had in place to seek feedback from people. We saw this was done by means of individual satisfaction surveys. We noted that each month a different topic was covered such as are people's religious, spiritual and nutritional requirements met and do people feel safe. Residents meetings were supposed to be conducted monthly with the agenda was displayed on the noticeboard. However we noted the last meeting documented was July 2017. We asked the deputy manager about this who explained that due to the current high needs of the people using the service, it was felt these meetings would not be effective. Following discussion, it was acknowledged by the deputy manager that these meetings should still go ahead despite current people's needs, to allow people to have a say about the service they received.

The registered manager had systems in place to monitor the quality of service being delivered. These included a variety of audits covering areas such as, falls, accident and incidents, care plans, infection control and recruitment. These audits were carried out by the deputy manager either weekly or monthly dependant on area. In addition to this the maintenance person was required to carry out weekly, monthly and annual audits on areas of safety and maintenance to evidence the building was in a good state of repair and people were safe. Areas such as window restrictors, radiator covers, water temperatures and appliance flushing to prevent the infection of legionella were some of the areas audited. It was the role of the registered manager to oversee each audit to ensure these were being carried out effectively. We were informed by the regional manager that a meeting was held weekly to look at the service compliance and develop an action plan for any identified areas of improvement.

The provider had a range of policies and procedures which provided staff with information about current legislation and good practice guidelines. In addition to this staff had been provided with a code of conduct and practice they were expected to follow. This helped to ensure the staff team were aware of how they should carry out their roles and what was expected of them.

The deputy manager told us she attended external meetings alongside the registered manager such as care home forums to enable partnership working. Care home forums provide an environment for managers to come together to share good practice examples and information sharing to drive up improvement throughout the Borough. The deputy manager told us she felt attending these meetings was beneficial and helped with the development of systems in the service. The deputy manager also informed us she was due to attend a further meeting that week, which provided an arena for home managers to share ideas to enable their services to obtain an outstanding status. This was being facilitated by the local council.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have an effective system in place for identifying and reporting to the local authority potential instances of abuse.