RYSA Highfield Manor Limited

Highfield Manor Care Home

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Overall summary

This was an unannounced inspection on 1, 2 and 15 October 2014.

Highfield Manor is registered to provide personal care for up to 46 people living with dementia. Nursing care is not provided. There were 45 people living at the home when inspected. The registered manager is also one of the directors of the provider RYSA Highfield Manor Limited. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

There were unsafe arrangements for the management and administration of medicines that put people at risk of harm. People were given sedative medicines routinely rather than when needed them and as prescribed by their GP. These people were subject to sedation at times when they did not need it and this placed them at risk of harm.

Summary of findings

Policies about keeping people safe and reporting allegations of abuse were out of date and one member of staff was not sure how they should respond to abuse.

Any risks to people's safety were not consistently assessed and managed to minimise risks. For example, behaviours that may challenge others and emergencies had not been risk assessed and planned for so staff knew what action to take. People's needs were not reassessed when their circumstances changed and care plans were not updated or did not include all the information staff needed to be able to care for people. This meant that for some people prompt action or referrals were not made to the right healthcare professionals and they did not receive the care they needed. People's need for social stimulation, occupation and activities were not consistently met.

People's care and monitoring records were not consistently maintained and we could not be sure they accurately reflected the care and support provided to people.

Staff did not have the right skills and knowledge to provide personalised care for people living with dementia. This was because they did not have a full induction into care, the right training or regular support and developments sessions with their managers.

Staff did not fully understand about the Mental Capacity Act 2005, and how to assess people's capacity to make specific decisions or about those people who were being restricted under Deprivation of Liberties Safeguards. This meant that some people may have been unlawfully deprived of their liberty or had restrictions place on them.

Some people had lost weight and prompt action had not been taken to ensure they had high calorie and high fat foods such as cream to increase their weight. Food and fluid plans were not in place for people who were at risk of losing weight so that staff knew what action to take to support them.

Information about making complaints was not displayed and contact information was incorrect. There were mixed views from relatives about whether they felt able to complain about the home.

The systems in place and the culture at the home did not ensure the service was well-led. This was because people were not encouraged to be involved in the home. People were not consulted, staff were not consulted and the quality assurance systems in place did not identify shortfalls in the service. The service did not have effective systems in place to ensure it was well led and people received a good service.

There were enough staff on duty during the inspection to meet people's needs and staff were recruited safely to make sure they were suitable to work with people. There were staff meetings and handovers to share information between staff.

Staff were caring and treated people with dignity and respect. Staff knew people's basic care needs and some personal information about them. We saw good relationships and interactions between some staff and people.

At our last inspection in November 2013 we did not identify any concerns.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

People were not kept safe at the home.

The management and administration of medicines were unsafe. People were given sedative medication routinely rather than 'as needed', as prescribed by their GP. This meant they were given sedation at times when they did not need it, which placed them at risk of harm.

Safeguarding procedures and training did not make sure that all staff knew and understood when and who they needed to report allegations of abuse to.

Risks were not always identified and managed to make sure people were kept safe.

People's records were not accurately maintained to make sure they reflected the care and support they had received.

Staff recruitment was safe and there were enough staff to make sure people had the care and support they needed.

Is the service effective?

Inadequate

People's needs were not effectively met.

Staff did not have the right skills and knowledge, training and support to meet people's needs.

People's rights were not effectively protected because staff did not understand the implications of the Mental Capacity Act.

Prompt action was not taken when people lost weight and they needed their food and fluid intake monitored.

People had differing opinions at to the quality of the food. They were not offered choices of food at the time of the meals which is important for people living with dementia. Snacks and drinks were not freely available so people could help themselves when they were hungry.

People's day to day health needs were met, but they were not always referred to specialist healthcare professionals when they needed it.

The design and décor of the home did not always take into account people's differing needs. For example to assist with people's orientation at the home.

Is the service caring?

Requires Improvement

The service was caring but some improvements were recommended.

People and their relatives told us staff were kind and caring.

Staff respected people's privacy and dignity.

Summary of findings

Staff had some understanding of people's preferences and how they liked to be cared for. Staff were not aware of everyone's life histories and the importance of using this information when providing care and support.

People and their relatives were not involved in the planning of their care.

People's independence was not always promoted and people could not move between floors of the home without staff support.

Is the service responsive?

Inadequate

The service was not responsive to people and their needs.

People's need to be kept occupied and stimulated was not consistently met. They did not receive care and support that was personalised to their preferences and personal histories.

People's needs were not reassessed when these had changed and their care plans did not include sufficient information about their care and support needs. This meant staff did not have up to date information on how to care for people.

Complaints information was not readily available so that people and relatives knew how to complain. Complaints were not responded to, investigated or the outcomes recorded. This meant that the provider was not able to use learning from complaints to improve the service.

Is the service well-led?

Requires Improvement

The home was not well-led.

Observations and feedback from people, staff and relatives showed us there was mixed views about whether the service had an open and inclusive culture.

People and staff were not asked for their feedback or asked to make contributions to the development of the service to the home.

The quality monitoring systems in the home were not effective to ensure the service delivered high quality care.

Highfield Manor 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.

This inspection took place on 1, 2 and 15 October 2014 and was unannounced. We carried out a planned inspection on 1 and 2 October and returned on 15 October to gather further information. There were three inspectors in the inspection team and two inspectors visited on each date. We met and spoke with all 45 people living at Highfield Manor. Because most people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with six visiting relatives, a visiting social worker, a district nurse, a chiropodist and the hairdresser during the inspection. We also spoke with the registered manager, two deputy managers and five staff.

We looked at five people's care and support records, an additional six people's care monitoring records, all 45 people's medication administration records and documents about how the service was managed. These included staffing records, audits, meeting minutes, maintenance records and quality assurance records.

Before our inspection, we reviewed the information we held about the service. This included the information about incidents the provider had notified us of. We also contacted one commissioner and four health and social care professionals who work with people using the service to obtain their views. We had contact from four different relatives before the inspection who raised concerns with us. We also had contact with four additional relatives following the inspection who also raised concerns with us.

We asked the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they planned to make. However, the provider told us they did not receive the request and did not complete this. We resent our request for this information after the inspection. This information had not been received at the time of us completing this inspection and was not used to inform judgements in this report.

Following the inspection, the registered manager sent us information about policies and procedures, end of life care, survey results, staff training and the training plan.

Inadequate

Is the service safe?

Our findings

People who were able to said they felt safe at Highfield Manor. One person said: "I'm comfy and happy here and I feel safe". We saw that other people freely approached and sought out staff. They smiled and responded positively when staff spoke with them. When people were upset or anxious they sought out staff to provide reassurance and comfort. This indicated people felt comfortable and safe with staff. For example, one person called out repeatedly and staff responded to the person's questions, gave them physical comfort and reassured them they were safe. Relatives told us they felt their family members were safe at Highfield Manor. However, we found significant shortfalls in the safety of the service.

We saw medicine stocks and management systems were audited on a monthly basis. We checked the controlled drugs storage and stock management systems in place. We found the stock and the controlled drugs record book balanced for the controlled medicines in use at the home.

The deputy manager responsible for ordering medicines told us they also audited the medication administration records each week. They said if any gaps or omissions were identified they checked against the stock to make sure that the medicine had been administered. They followed up with individual members of staff where gaps were noted. However, these audits were not effective as they had not identified the shortfalls we found.

The deputy manager told us there were nine staff who were trained to administer medicines. Records showed us three of these staff had their competency to administer medicines assessed in February and March 2014. However, six of the staff who administered medicines had not had their competency assessed. This meant that people could not be assured that these staff had the knowledge and skills to administer medication. There was no schedule to determine how often staff competency was going to be reassessed to ensure that staff were able to continue carrying out this task safely.

We looked at the medicines plans, administration and monitoring systems in place for people. People who had PRN (as needed) sedative medicines prescribed were given these medicines routinely rather than when they needed them. These medicines had been prescribed to be given 'as needed' rather than routinely. Therefore people had been given sedation at times when they did not need it, which placed them at risk of harm. There were no 'as needed' medicine plans in place to make clear to staff the circumstances when they should administer these medicines, the maximum dosage and the time between doses. We raised this serious shortfall with the manager and deputy managers on the 1 and 2 October 2014. When we returned on 15 October 2014 we found this practice had continued and people had continued to have sedative medicines on a routine basis. In addition to this, 'as needed' medicine plans were still not in place to advise staff when these medicines should be given.

For some sedative medicines medication administration records did not detail whether half or a whole tablet had been administered. This meant that a stock balance could not be established and we could not be sure of the amounts that had been administered to the person. One person's sedative medication administration record had been signed for 11 times but there were19 tablets missing from the medicine blister pack. (This is a type of monthly medicine administration dosage packet dispensed from the pharmacy). This meant eight sedative tablets had been removed from the pack, but the records did not state what had happened to this medicine.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there were not appropriate arrangements for the administration, and recording of medicines.

The safeguarding policy was out of date, did not make references to offences under the Mental Capacity Act 2005 and did not include the correct details for the local authority for staff to report any allegations of abuse. Staff had been trained in safeguarding as part of their induction. All of the staff we spoke with were confident of the types of the abuse and how to report any allegations. However, one staff member said they would speak with a staff member if they witnessed them shouting at someone rather than reporting it but if it happened again then they would then report it. This was an area for improvement because the safeguarding policy did not provide staff with the contact information on how to report allegations of abuse and some staff may not have responded appropriately to any allegation of abuse.

People had risk assessments and management plans in place for falls, pressure areas and nutrition. However, there were no assessments and management plans in place for

Inadequate

Is the service safe?

other risks. For example, two of the three people who had bed rails to minimise the risk of them falling out of bed, did not have a risk assessment completed to ensure that bed rails were appropriate to meet their needs. People who sometimes showed behaviours that challenged others did not have these risks assessed and behaviour management plans were not in place. This meant that staff did not have information about how to manage people's behaviours in a safe and personalised way.

Two of the five people's care records included a personal evacuation plan. For the remaining three people this information was not available, therefore staff and emergency services may not know how to safely support these people in an emergency.

These shortfalls in risk assessments and management plans, and emergency plans were a breach in Regulation 9 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care and monitoring records were not consistently maintained and we could not be sure they accurately reflected the care and support provided to people. For one person daily records were not completed for one night and for another person their name was recorded differently in different records. Three people's fluid records had not been added up to make sure they had enough to drink, and according to the records we saw those people did not drink the target amount recorded on their monitoring records. Two people's weights were inaccurately recorded on their care plans and food and monitoring records. We found an eating and drinking plan for another person in one person's care plan. This was a potential risk because the care plan did not accurate reflect the care and support for this individual.

These shortfalls in record keeping were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and relatives said there were enough staff most of the time. One relative said: "Staff respond really quickly if you ask for help". The district nurse and chiropodist told us there were staff available when they needed them. However, some people gave us conflicting opinions that staff were not available at the times when they wanted support. One person said: "The staff seem to disappear completely in the evenings and you have to get undressed when they say and don't always have choice about what time to get up in the mornings". Another person said: "When I use my call bell at night it can be a while (for staff to arrive)… it feels that we have to adapt to the staff rather than the staff adapt to us".

We observed during the inspection there were enough staff to meet people's needs. The deputy manager acknowledged that additional staff were on duty because of the inspection so managers could be freed up to support the inspection. The number of staff on duty during the inspection did not reflect the usual number of staff working. We looked at the last four weeks' staff rotas and found they reflected the staffing levels the deputy manager and staff told us. Additional staff had been working between 8pm and 10 pm from 8 September 2014. The manager and deputy manager told us this was in response to an increase in people's needs. We explored with the manager and deputy manager how they determined the amounts of staff they needed. However, they were not able to demonstrate how they worked out staffing levels and whether it was based on people's individual needs. This was an area for improvement as they were not able to relate staffing levels to people's needs.

We looked at four staff recruitment records and spoke with one member of staff about their recruitment. We found that recruitment practices were safe and that the relevant checks had been completed before staff worked with people. This made sure that systems were in place to protect people from individuals who were known to be unsuitable.

Inadequate

Is the service effective?

Our findings

Staff did not receive adequate supervision, appraisal and training to enable them to fulfil their roles effectively. Two staff told us they had one-to-one support and development meetings with their line manager and they felt supported. We saw records of a support session in August 2014 for three of the staff. There were no other records of one-to-one sessions in these staff files. The manager and deputy manager responsible for the day-to-day management of the home acknowledged they had not had formally recorded one-to-one sessions with the staff they were responsible for. There was a supervision (one to one) plan and the one-to-one record that detailed these support sessions were 'bi-monthly' but these had not happened as planned. The manager told us there were plans to implement annual appraisals but these also had not been implemented. There was no training plan in place to make sure staff had the correct skills and knowledge to meet people's needs.

Staff completed core training, for example, infection control, moving and handling, safeguarding, fire safety, health and safety and food hygiene. The home is a specialist dementia care home. Eighteen of the 23 staff had completed one day basic dementia awareness training. However, from our observations, and discussions with people, staff and relatives, we found the staff did not have the skills and knowledge in dementia care to be able to meet people's social and emotional needs.

One of the three deputy managers had not had any induction training when they started at the home in April 2014. This was confirmed by the other deputy manager responsible for their induction. We also spoke with a recently recruited member of staff. They told us they had completed an induction and training, which included working through an induction checklist and shadowing other staff. The registered manager showed us the induction programme for care staff. However, we noted that this induction programme was not based on the Skills for Care Common Induction Standards, which are nationally recognised induction standards. We discussed this with the registered manager because this was an area for improvement as these are the induction standards recognised by the care sector to prepare staff for their role.

These shortfalls in the staff's skills and knowledge, training, supervision and induction were a breach of Regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The deputy manager, responsible for the day to day running of the home, had started a long distance MSC in Dementia Studies with the University of Bradford. They told us they planned to share their learning with the staff group. The manager told us they kept up to date with good practice in dementia care by regularly reading information from the Alzheimer's society. It was not clear how this information was shared with staff.

The service was not meeting the requirements of the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards. The manager and deputy manager had some understanding of who had restrictions placed on them and they had made applications for these to be authorised under Deprivation of Liberty Safeguards (DoLS). However, staff were not aware of the Mental Capacity Act 2005, making best interest decisions, or which people were being deprived of their liberty and who had DoLS authorised. One person's DoLS authorisation documents detailed they needed specific care plans for staff to follow but these were not in place. People's care plans included the blanket statement: "(person) has no capacity". This showed us the managers and staff did not understand the presumption that people have capacity to make decisions for themselves. Capacity assessments had not been completed so specific decisions could be made in people's best interests. In addition to this there were no mental capacity assessments or best interest decisions recorded about the use of bed rails where people were unable to give consent.

The lack of mental capacity assessments and best interest decisions was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because suitable arrangements were not in place for obtaining consent for people and conditions of DoLS were not being followed.

People gave us mixed opinions about the meals at the home. Comments from people included: "Sometimes the food is cold… we get them (drinks) when they dish them out", "We're not hungry but we don't have any snacks or fruit to pick at", and "Food is variable, it's a let-down". Some relatives commented on the small portions of food and the lack of variety and choice. One relative said: "We have seen

the same meal over and over again". People and relatives told us, and we saw, that snacks, fruit and drinks were not readily available in the home for people to help themselves when they were hungry or thirsty.

We observed the main mealtime in the ground floor lounge and the lower ground floor lounge area. During our observations, people were not given a visual or verbal choice of meal at the time of the meal. This meant people living with dementia may not have been able to recall what they had ordered for each meal the previous day.

People on the lower ground floor were not supported to eat at a dining room table. This meant that people may not have understood that it was mealtime until their meals were placed in front of them. In the ground floor dining room, staff sat at the table with people to support them to eat their meals.

Coloured crockery was used throughout the home. This was good practice and research has shown that people living with dementia can see food more easily on coloured crockery and may subsequently eat more.

People's food likes and dislikes were recorded in their assessments and some information was included in people's care plans. However, this was not consistently followed, for example, one person's plan detailed they did not like sandwiches but their food records showed they had been given sandwiches. This did not acknowledge this person's dietary preferences.

People had their nutritional needs assessed but care plans to manage these were not consistently put into place. People's weight was monitored on a monthly basis but prompt action was not always taken when people lost weight care plans were not always updated to reflect what action staff needed to take. Food and fluid monitoring did not always start after weight loss was noted. The care plans and food records did not detail whether people were to receive fortified foods (e.g. added full fat cream, full fat milk with milk powder added, full fat cheese). We saw some food records that showed one person had food fortified for three weeks but then the records did not show that they continued with this. Other people's records did not show whether they were having fortified diets in response to weight loss.

This shortfall in taking action in response to people's weight loss was a breach of Regulation 14 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people's day to day health care needs were met. We saw records to show people were seen by the GPs, chiropodists, district nurses and community mental health professionals. GPs told us the managers at the home contacted them appropriately for advice and visits where necessary. However, people were not consistently referred to health professionals following weight loss, or changes in people's moods and mental health.

People who were at risk of developing pressure sores were regularly repositioned to relieve pressure and records of their position throughout the day were kept. A district nurse told us that staff at the home referred people to their team when needed and any specialist equipment such as pressure-relieving cushions and mattresses were provided promptly.

We looked at the design and adaptations in the home to see whether it met the individual needs of people living with dementia. We saw some signage in the home so people could identify and recognise toilets and bathrooms. However, the majority of décor was in neutral colours and for some people living with dementia they would not have been able to distinguish the differences between doors, furniture and walls. Not all people's bedroom doors had their name on it. Most doors had a current photograph of the person and their name on but people living with dementia may not have recognised themselves in the photographs. There was nothing on bedroom doors to make it easier for each individual to recognise their bedroom.

In the ground floor lounge/dining area there was a wipe board with the date and day of the week on it. People who spent time on the second floor lounge told us they did not know what the day was and when they used to spend time in the downstairs lounge they always knew and they missed this information. There were not any signs to let people know what day and date it was on the second floor or lower basement seating areas. This was an area for improvement to support people to orientate themselves to the day and date.

Requires Improvement

Is the service caring?

Our findings

One person told us staff respected their privacy and dignity. They said: "They always knock on the door; they are gentle when they help me wash and they keep me covered up". We observed staff respecting people's privacy; they knocked on people's bedroom doors and sought permission before going in. On the second day of the inspection one person had a fall in the ground floor lounge at lunchtime. The managers and staff managed the situation calmly reassured the person and called paramedics. Staff maintained the person's dignity by using portable screens whilst they were being examined.

Overall, relatives we spoke with were positive about the care provided. Relatives' comments included: "The staff are really friendly", "For me this has become a home from home because they have made me so welcome" and "They respect me as well".

Staff were warm in their approach and treated people with compassion and respect. For example, one person was distressed and staff listened to them, offered them a cuddle and reassured them. The person relaxed and then chatted and smiled with staff. In the main, staff responded when people called out and staff spent time talking with people when they asked for staff attention.

Staff had a basic understanding of people's needs, some of their personal preferences and the way they liked to be cared for. However, people were not routinely consulted or involved in developing their care plans. Relatives had been involved in people's assessments and had signed some people's care plans. However information gathered on people's life histories and personal preferences was not used to plan people's care, support and social stimulation and occupation. This meant that people were not able to engage in meaningful activities and were not kept occupied doing things that were important to them.

We recommend that people and or their relatives be involved in planning their care and support. People's life histories and personal preferences should be used to inform their care is planned and delivered. This is so people receive a personalised service.

People's independence was not actively promoted. We did not see people being involved in activities of daily living such as making drinks, laying tables or helping with other tasks around the home.

During the inspection people moved freely about the floor they were living on. However, one relative told us people were routinely told to 'sit down' when they visited. Two people commented that they were not able to move independently about the home because they did not know how to work the lift and were reliant on staff to use it. They said they had previously used the ground floor lounge and gardens and now they were asked to use the second floor lounge and this meant they felt more isolated.

We recommend that people's independence is promoted so they are able to freely move about all areas of the home and are involved in daily living activities.

Relatives told us they were free to visit when they wanted. However, one relative told us they were discouraged from visiting at mealtimes and they had been made to feel uncomfortable about chatting with their family member during a mealtime visit. We asked the manager whether there were any restrictions on visiting and they told us they had introduced 'protected' mealtimes so that people could eat without distractions. They said that they had advised relatives they could have a meal in private with their family member if they wished.

Inadequate

Is the service responsive?

Our findings

In the ground floor lounge staff played ball and skittle games with people. We saw there were giant games, such as Four in a Row, available. However, we did not see staff playing these games with people or keeping people occupied in the second floor lounge. The staff we spoke with did not have an understanding of how to provide personalised activities for people and this information was not included in care plans. For example, they did not understand how they could use people's life history and how they had previously kept themselves occupied to develop individual ways of stimulating and occupying people.

We observed one person sitting in their bedroom; they had two family photographs but no other pictures in their bedroom. They did not have a television or the means of listening to any music. They said: "I love music, like rock and roll, dancing and I like ironing and gardening". Another person said: "I'm sitting here doing nothing, I like cars and I used to potter around the house, I liked to go into the garden". A third person said: "There's nothing to do. I sit here like a cabbage, I literally don't do anything". Three people told us because the staff's first language was not English it was hard to have fluent and chatty conversations with them.

One relative said: "They have some entertainment but often its people just sitting, there's not much going on during the day" and another relative said: "It's not as stimulating as it can be". Other relatives also told us they also had concerns about the levels of activities and stimulation for their family member.

Relatives had differing opinions as to how well they were kept informed about the care of their family member if they were not able to make decisions themselves. For example, one relative told us they were regularly contacted and updated when they visited. However, another relative felt they hadn't been kept up to date about professionals who had visited their family member.

Before people moved into the home the manager or deputy manager completed an assessment. However, as identified in the 'safe' and 'effective' sections of this report , care plans were not always put in place therefore staff did not have information on how to meet their assessed needs. Where there were care plans in place, staff did not always follow these to deliver the care people needed.

People's needs were not reassessed and their care plans were not updated when their needs changed. This meant for these people they may not have received the care and support they needed. For example, one person had a fall two weeks before the inspection but their falls risk assessments and care plan were not updated to reflect the changes. We raised this with one of the deputy managers, who reviewed, changed and backdated the care plan in our presence.

Another person had been steadily losing weight since their admission into the home ten months ago. This steady decline in weight had not been identified by the staff completing the monthly reviews. Their weight loss was only picked up when the person's weight loss increased significantly. However, staff had not started monitoring the person's food and fluid intake until two weeks after the significant weight loss was identified. In addition to this there was no dietary care plan that detailed whether the person was to receive fortified foods. The person had been referred to health care professionals the day before the inspection but the deputy manager told us this had been prompted by a mental health professional raising concerns and rather than by their monitoring systems.

During the inspection one person was lying on their bed and was choosing not to get up. They had also lost weight since their admission in May 2014. They were assessed as high risk of malnutrition but there was not an eating and drinking plan in place in relation to their weight loss. Staff told us this person had chosen to remain in bed about three months ago. The GP had visited this person when they were chesty but no consideration had been given to requesting a mental health professional or dietician referral following them choosing not to get out of bed and their significant weight loss. In addition to this their beard was long and unkempt and the person told us: "I don't like my beard long". This person's care plan included they liked their beard trimmed with an electric trimmer. This meant staff had not responded to meet their personal care needs.

One person told us they were uncomfortable and their shoulder was sore. This person was cared for in bed and spent at least three hours lying on one side. We asked the deputy manager and a staff member about the person's

Inadequate

Is the service responsive?

pain relief. They told us the person had been given their pain relief as prescribed. This was confirmed in their medication records. The person had a pain relief patch that was applied to their skin and this was due to be changed later that day. Staff reported the person was often quiet and complained of pain before the patch was due to be changed. However, there were no assessments of this person's pain levels using a pain assessment tool to evaluate the effectiveness of this pain relief.

Information was gathered during people's assessments about their religious and cultural needs. However, but these needs were not planned for so staff knew how to support people.

These shortfalls were a breach in Regulation 9 (a) (b) (i) (ii)Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because these people were not receiving the social stimulation and care and support they needed to meet their care, support and emotional well-being needs. This was because their needs had not been assessed and care plans had not been put in place or they had not been followed.

There were mixed responses from people and visiting relatives about whether they felt comfortable in raising concerns and complaints directly with the manager and deputy manager. There were two examples of where health and social care professionals had needed to raise concerns with the manager because relatives did not feel their concerns had been identified or addressed. Relatives who contacted us before the inspection did not feel able to raise their concerns with the managers. Other people and visiting relatives said: "I've got no complaints at all", "if I've got any concerns I go to the office", "(manager) and (deputy manager) said to go to them not a carer if they have a concern", and, "I wouldn't feel comfortable raising concerns". We saw memo to staff reminding them to speak English and complete records accurately. The manager told us this was in response to concerns being raised. The manager and deputy manager told us they informed people and their relatives about how to raise concerns on admission into the home.

The complaints procedure was not displayed in the home and was not readily available to people or visitors. The procedure did not include how people could complain to their funding authority, the correct role of CQC and the ombudsman. The complaints records included one complaint from a relative, a complaint from a staff member and two recent safeguarding allegations. However, complaints records did not show that complaints were investigated, responded to or the outcomes recorded as detailed in the complaints policy. There was not any evidence of how learning from complaints was regularly shared with staff to improve the quality of the service.

This was a breach of Regulation 19 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because some people did not feel able to bring complaints to the attention of managers, the complaints procedure was not accessible to people and the complaints procedure was out of date and did not include the different ways people could complain.

Requires Improvement

Is the service well-led?

Our findings

There was not an inclusive and open culture. The manager and deputy manager told us they did not routinely consult with people. Some people who were able to told us they were not involved in developing the home or consulted about things like activities. People living with dementia were not given the opportunity to share their views and contribute to the running of the service.

Relatives had an opportunity to be involved and were consulted about the home. However, not all relatives felt they were encouraged by managers to be involved. There had been a relative's meeting in July 2014 and four relatives had attended. The manager had arranged for a small number of visitors and relatives to attend a dementia awareness session. Three relatives told us: "I feel like the doors always open", "Any questions we've had they've been very honest", "(manager) checks that I'm happy with everything", and "I filled in a form the other day about what could be better". We saw six compliment letters from relatives. People's relatives had recently completed surveys and the manager told us they had followed up with individual relatives any concerns they raised. However these surveys were not dated and did not feed into any development plan to ensure that the feedback was used to improve the service.

The management structure of the home consisted of the registered manager was also one of the directors of the provider, the deputy manager responsible for the day to day running of the home and two additional deputy managers

Staff and managers told us there were handovers at the start of each shift where they discussed each person and any change in their needs. They also discussed any urgent matters and plans for the day. Although staff told us and records showed us there were regular staff meetings, staff did not have the opportunity to regularly discuss issues, express their views and influence the development of the home. From discussion with the managers, staff and from meeting records there was no evidence of how learning from incidents, accidents, safeguarding and compliments, was shared with staff to improve the service provided.

Three staff told us they knew how to whistleblow and there were policies in place to support this. We saw an example where a member of staff had raised concerns about another member of staff and the manager had taken appropriate action.

Prior to our inspection we had asked the provider to complete a Provider Information Return (PIR) containing information about the operation of the home. However, the provider told us they did not receive the request and did not complete this. We resent our request for this information after the inspection. However, the provider had not returned this information as required, and therefore this information could not be used to inform judgements in this report.

Policies and procedures were out of date and some included incorrect information. If staff relied on these policies they would not have had the correct information and this may have placed people at risk of not receiving the right care and support. The policies and procedures that were sent to us were for the provider's other care home. Policies such as the complaints, safeguarding policy and quality assurance policies differed to those we saw in the home and staff may not have been sure which were the correct policies to follow.

Notifications had been made to us for a majority of incidents. However, the manager had not notified us of safeguarding allegations and investigations as required by the regulations. This meant the provider had not shared information with us appropriately regarding safeguarding allegations and we were reliant on the local authority to notify us of these incidents.

This was a breach of Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009 because the provider had not notified the Commission of incidents affecting people.

The quality assurance systems in place were not effective and did not drive improvement in the quality of care and service provided. For example, the monthly care plan audits identified shortfalls but these were not followed up to make sure the issues had been addressed, it was not clear how any actions identified from other audits were followed up and the quality assurance policy referred to having a development plan but this was not in place.

Requires Improvement

Is the service well-led?

The quality assurance systems were also not effective in assessing and monitoring the quality of the service. The provider and management team had not identified the significant shortfalls we found during the inspection.

These shortfalls in how well led the service was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving unsafe or inappropriate care because they had not assessed, planned and delivered the care to meet service user's needs and ensure the welfare and safety of each service user.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person had not ensured that service users were protected from the risks of unsafe or inappropriate care because they had not maintained accurate records of the care and treatment provided to each service user.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place to ensure that persons employed for the purposes of carrying on the regulated activity received adequate training, supervision and appraisal.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person did not ensure that service users were protected from the risks of inadequate nutrition and hydration by means of the provision of a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service user's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person did not have an effective system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by service users, or person's acting on their behalf.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Service users who used services were not protected from unsafe or inappropriate care because the registered person did not regularly assess and monitor the quality of service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not notify the Commission of incidents affecting people living at the home.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person was not protecting service users against the risks associated with the unsafe use and management of medicines.

The enforcement action we took:
We have issued the provider with a warning notice relating to the management of medicines. The provider must comply with this regulation by 14 November 2014.