High Pines Residential Home Limited

High Pines Residential Home Limited

Inspection report

47 Pigeon Lane
Herne
Herne Bay
Kent
CT6 7ES

Tel: 01227368454

Date of inspection visit:
13 January 2016
15 January 2016

Date of publication:
24 February 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on 13 and 15 January 2016 and was unannounced.

High Pines Residential Home provides accommodation for up to 27 older people who need support with their personal care, some people are living with dementia. Accommodation is arranged over two floors. A lift is available to assist people to get to the upper floor. The service has 25 single bedrooms and one double bedroom which people can choose to share. There were 22 people living at the service at the time of our inspection.

A registered manager was in post and leading the service on a day to day basis. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager did not provide strong leadership to the staff and did not have oversight of all areas of the service. The registered provider was helping them to develop these skills. Staff were clear about their roles and responsibilities but checks were not completed to make sure they fulfilled these.

People were treated with dignity and respect. For example, staff explained the care and support people would receive before they received it and asked them what they would like staff to do and when.

The provider took action during our inspection to make sure there were enough staff, who knew people well, to meet their needs at all times. The needs of the people and skills of staff were considered when deciding how many staff were required on each shift.

Staff recruitment systems were in place and information about staff had been obtained to make sure staff did not pose a risk to people. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff were not consistently supported to provide good quality care and support. Staff met regularly with the manager to discuss their role and practice and any concerns they had; however, these meeting were not planned and staff did not have time to prepare for them. Staff did not get the maximum benefit from these meeting. A plan was in place to keep staff skills up to date. Some staff held recognised qualifications in care.

Staff knew the signs of possible abuse and were confident to raise concerns they had with the provider or the local authority safeguarding team. Plans to keep people safe in an emergency were in place.

People's needs had not been consistently assessed to identify the care they required, especially when their

needs changed. Care and support was not planned with people and reviewed to keep them safe. Detailed guidance had not been provided to staff about how to provide people's care. This had a limited impact on the care people received because people's needs were generally known by staff.

People received the medicines they needed to keep them safe and well. Action had not been taken to make sure people received all their 'when required' medicines when they needed them. The side effects of medicines were not managed to minimise their impact on people. People were supported to attend health care appointments and to have regular health checks.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The conditions of DoLS authorisations had not always been complied with and there was a risk that people were not supported to go out when they wanted to. Applications had been made to the supervisory body where they were necessary.

Consent to care had been obtained from people. People who had capacity were supported to make decisions and choices. Processes were not in operation to assess if people were able to make decisions. Decisions were made in people's best interests when they were not able to make the decision themselves. The requirements of the Mental Capacity Act 2005 (MCA) had not been fully met.

The activities offered at the service did not meet everyone's preferences and most people were not involved in planning the activities on offer. The provider was looking to recruit a new activities coordinator to work at the service.

The provider had recognised that possible risks to people had not been consistently identified and was putting new processes in place to assess and manage the risks to people. This included a new process to look for accident patterns and trends.

People told us they liked the food at High Pines. They were offered a balanced diet that met their individual needs, including low sugar diets for people who wanted them. A range of foods were on offer to people each day and people were provided with regular drinks to make sure they were hydrated.

People and their representatives were confident to raise concerns and complaints they had about the service with staff and had received a satisfactory response.

Regular checks on the quality of the service people received had not been completed to make sure that it was to the required standard. Shortfalls had not been identified so they could be addressed to prevent them from happening again. People, their representatives and staff had been asked about their experiences of the care but this had not been used to improve the service. Views shared with the manager had not been consistently acted on and not everyone had received feedback about the action taken to address the issues they had raised.

The environment was safe, clean and homely. Maintenance and refurbishment plans were in place. Appropriate equipment was provided to support people to remain independent and keep them safe. Safety checks were completed regularly.

Records kept about the care and support people received were not always accurate and up to date.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We made some recommendations to improve practice including that the provider seek advice and guidance from a reputable source about effective systems to assess people's capacity to make decisions and review the application of their staff supervision and support processes.

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

Some risks to people had not been assessed and guidance had not been given to staff about how to keep people safe at all times.

Staff knew how to keep people safe if they were at risk of abuse.

The provider took action to make sure there were enough staff who knew people well, to provide the support people needed at all times.

Guidance had not been given to staff about giving people 'when required' medicines. Action had not been taken to minimise the impact of the side effects of medicines on people. Other medicines were given to people when they needed them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always follow the Mental Capacity Act (2005) and people's capacity to make particular decisions had not been assessed. Decisions were made in people's best interests by people who knew them well.

A plan was in place to make sure that staff completed all the training they required and important training was prioritised.

People received food and drinks they liked to help keep them as healthy as possible.

People were supported to have regular health checks and to attend healthcare appointments.

Is the service caring?

Good

The service was caring.

People said the staff were kind and caring to them.

Some information about people's life history and their background was recorded. Staff knew about specific details of

people's lives but these were not always recorded.

People were given privacy and were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service not consistently responsive.

Regular assessments had not been completed to identify changes in people's needs.

People's care plans did not contain all the guidance staff needed to provide people's care in the way they preferred.

Most people were not involved in planning the activities on offer and the activities provided were not what everyone preferred.

Action had been taken to resolve people's concerns to their satisfaction.

Is the service well-led?

Requires Improvement

The service was not well-led.

The registered provider had identified that the manager was not providing staff with clear strong leadership and was providing them with support and guidance to develop these skills.

Staff were clear about their roles and responsibilities but checks had not been completed to make sure they were being fulfilled.

Checks on the quality of the care were not completed regularly. Some people and staff had shared their experiences of the service and made suggestions but these had not been acted on.

Records about people and the care they received were not always accurate and up to date.

High Pines Residential Home Limited

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 was planned to check 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 13 and 15 January 2015 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at notifications we had received from the registered manager. Notifications are information we receive from the service when significant events happen, like a death or a serious injury.

During our inspection we spoke with people living at High Pines Residential Home, the registered manager, the registered provider, staff and people's relatives. We visited people's bedrooms, with their permission; we looked at care records and associated risk assessments for five people. We looked at management records including staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes. We observed the support provided to people. We looked at medicines records and observed people receiving their medicines.

We last inspected High Pines Residential Home in October 2013. At that time we found that the registered provider and manager were complying with the regulations.

Requires Improvement

Is the service safe?

Our findings

At the beginning of our inspection people and their relatives told us that at times there were not always enough staff on duty to respond promptly to their needs. One person's relative told us, "From time to time there are not enough staff", they also said that the staff, "Worked their socks off".

Four staff provided people's care in the morning. On weekdays this included the manager who also completed management tasks which took them away from the people's care. This delayed the help and support that people needed. The provider took action during the inspection and added an extra member of care staff to rota each morning. Staff told us this gave them time to spend with people and provide their care at the pace they preferred.

A call bell system was fitted in peoples' bedrooms and communal areas. People did not use the bells to call staff during our inspection but people told us that staff came quickly when they had used the call bell in their bedroom. A call bell was fitted in the lounge but this was not accessible to people and people relied on staff checking on them to make sure they were safe and well. Staff were not always present in communal areas with people. During the inspection the provider took action and allocated staff to monitor people regularly.

Cover for staff sickness and holidays was provided by other staff members in the team. An on call system was in place and management cover was provided at the weekends and in the evenings, so staff had support when they needed it. The staff team was consistent and staff turnover was low. People received care, from staff who knew them well. Housekeeping and catering staff were employed and care staff were free to concentrate on providing the care and support people needed.

People and their relatives told us they felt safe at High Pines. There were policies and processes in place to keep people safe, these were known and understood by staff. Staff had completed safeguarding training and knew the signs of possible abuse. They were confident to raise safeguarding concerns or 'whistle blow' to relevant people. Some staff were not confident that the manager would act on safeguarding information and told us they would inform the provider who they trusted to act.

Risks to people had been not been assessed consistently. The provider knew about this and had started to assess risks to people, such as the risk of them falling. A process to assess people's moving and handling needs was in place but had not been used consistently at the service. Guidance had not been given to staff about how to move everyone safely. We observed that staff supported people to stand and sit safely. However, there was a risk that people would not always be moved safely. This was an area for improvement.

Risks to peoples' skin, such as the development of pressure ulcers, had not been assessed. Without individual risk assessments looking at all the factors that may affect a person's skin, people could not be sure that staff would take the right action to lower the risk. Staff knew the signs that people were at risk of developing pressure ulcers and had referred people to their doctor or nurse. Special equipment, such as cushions and mattresses were provided to keep people's skin healthy, we observed these being used.

Information about the correct settings for special mattresses and cushions was available to staff. Cushions we checked were at the right setting and people got the maximum benefit from them.

Accidents and incidents involving people were recorded. A process was in operation to review each accident but not to look at patterns and trends. Unwitnessed accidents, such as falls, which did not result in an injury, were not reviewed. We found that one person had been 'found on the floor' several times but the registered manager had not recognised that they were falling. The provider had begun to develop a process to look for patterns and trends, especially in relation to falls, to make sure that risks were identified and people were referred to health care professionals when they needs changed.

The registered manager had failed to assess all the risks to people's health and safety and ensure that action was taken to manage those risks. This was a breach of Regulation 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Plans to evacuate people in the event of an emergency considered each person's needs. The provider had recently confirmed that the lift could be used in an emergency. They had contacted a fire safety consultant to obtain advice on evacuation plans and special equipment to support people to evacuate safely. Staff were confident to contact the manager for support in an emergency. Contingency plans were in place to keep people safe, including moving people to another local service if they were unable to stay at High Pines.

People and their relatives told us the service was always clean and odour free. All areas of the service were cleaned regularly and domestic staff worked at the service each day. The building and equipment were well maintained and regular checks, such as hoist safety and electrical checks had been completed. Maintenance plans were in place. The temperature of bath and tap water were checked regularly and staff knew the correct temperature range to make sure people were protected from the risk of scalding.

The building was secure and the identity of people was checked before they entered. Internal doors were not locked and people moved freely around the service and were not restricted. Fire and environmental risk assessments had been completed and action taken to keep people safe. An enclosed garden was available at the back of the service.

Furniture was of a domestic nature and the service was comfortable and homely. Lots of small tables were available in the lounge and people had drinks and other personal items near to them. People were able to bring personal items with them into the service and these were on display in their bedrooms. One person told us, "I can have my room the way I want it".

Staff recruitment processes were in place to protect people from staff who were not safe to work in a care service. Information about staff's conduct in previous employment had been obtained and checked. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Information about candidate's physical and mental health had been requested and checked. Other checks, including identity checks, had been completed.

Processes were in operation to protect people from the risks of unsafe management of medicines, including systems for ordering, checking, disposal and administration of prescribed medicines. Medicines were stored securely. People received their medicines at the time advised by their doctor. Staff's medicines administration skills were assessed annually to make sure they continued to use safe practices.

Staff knew the side effects of some people's medicines; however, people were not supported to manage

these and their care had not been planned to minimise the impact of the side effects on them. For example, one person took medicine daily which caused them use the toilet frequently for a couple of hours after taking it. They were offered their medicine at 7:30 am and had their breakfast at 8:00 am. Their breakfast was interrupted by several visits to the toilet each day and this distressed them. Staff knew about this but had not changed the time the person took their medicine so they could eat their breakfast undisturbed.

Some people were prescribed medicines 'when required' (PRN), such as pain relief or for symptom relief. Guidance about how to manage each person's PRN medicines had not been provided to staff and there was a risk that people would not receive their medicine when they needed it. For example, one person had a PRN medicine to relieve the symptoms of a heart condition. Staff knew the symptoms the person may feel but not how they would recognise the symptoms if the person was not able to tell them how they were feeling. Detailed guidance was included on the medicine packaging, including when to administer it and the action to take if it was not effective but this had not been used to plan the person's care.

Staff asked people if they wanted pain relief regularly and only gave it when they wanted it. All the people prescribed PRN pain relief at the time of the inspection were able to tell staff when they needed it.

Some people were prescribed creams to help keep their skin healthy. Guidance had not been provided to staff about when and where to apply prescribed creams. The manager had a template cream application record but had not used this to provide staff with guidance about the effective application of people's creams. There was a risk that creams would not be used correctly and people would not get the maximum benefit from them.

The registered manager completed a medicines check monthly. The checks had not identified that hand written entries on medicine administration records (MAR) were not always signed and had not been double checked to make sure they were accurate. Staff had not recorded consistently on MAR when medicines had been stopped or were no longer required. There was a risk that people's MAR would not be accurate and they would not be protected from the risk of incorrect medicine administration.

The registered manager had not taken action to ensure that people's medicines, including 'when required' (PRN) medicines, prescribed creams and the side effects of medicines, were managed safely at all times. The registered manager had not taken action to make sure that people's medicine records were accurate. This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

People were able to make choices about their lives, such as when they got up, when they went to bed and what they ate. People chose how they spent their time and who they spent it with. During our inspection people were offered choices and staff responded consistently to the choices they made.

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. Some people living at High Pines were not able to tell staff how they preferred their care and support to be provided.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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. The manager did not have a good understanding of the requirements of the Mental Capacity Act 2005 (MCA). They had received training in relation to the MCA, however they needed to develop their knowledge and skills further to make sure that they complied with the MCA. For example, people's capacity to make decisions had not been assessed, and staff did not know what decisions people were able to make for themselves and the support they required to do this.

Everyone was able to make straightforward decisions, such as what they wanted to eat or drink and communicated these to staff. Staff knew people's preferences, such as cups they liked, and these were provided.

Some people were unable to make complex decisions about the care and treatment they received and needed other people to make these decisions in their best interests. Decisions made in people's best interests had been made by relatives and friends who knew them well, with staff, and health and social care professionals on occasions. Records of the reasons for decisions and who had made them had not been kept.

We would recommend that the provider seek advice and guidance from a reputable source about effective systems to assess people's capacity to make decisions and how to record decisions made in their best interests.

Staff were aware of some of their responsibilities under DoLS. Applications had been made for standard authorisations for some people. An assessment of the risk of people being deprived of their liberty had not been completed to check if people had the capacity to leave the service when they wanted to.

One person had conditions on their DoLS authorisation requiring staff to support them to go out regularly. The manager did not know the condition was in place and the person had not been supported to go out. The person had been asking staff in they could go out and had become angry at times when they could not go out. The manager had not recognised that the person was requesting to go out or the impact of not going out on them. We told the local authority about our concerns about the management of this person's DoLS authorisation conditions.

The registered manager had failed to comply with the conditions of the Mental Capacity Act 2005 Deprivation of Liberty authorisation. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of our inspection we observed that some people were not able to leave the table when they wanted to as their chair was pushed up against the wall and a table was placed in front of them. The manager had not recognised that people were not able to get up when they wanted to and there was a risk that they were being restrained. The provider took immediate action to rearrange the furniture in the dining room and offered people alternative places to eat, such as the conservatory, this removed the risk of people being restrained.

Staff had received an induction when they started work at the service to get to know people, the care and support they needed and to understand their roles and responsibilities. A process to assess staff's skills at the end of their induction was in place. New staff worked alongside experienced staff to help them build relationships with people and learn how their care was provided.

Staff had received the training they needed to perform their duties. The provider had a plan in place to provide training to staff and took action to prioritise important safety training that staff required such as moving and handling training. Some staff had completed further qualifications such as level 2 or 3 qualifications in social care. Regular checks of staff's skills were completed, including administration of medicines and moving and handling.

Some staff told us they did not feel supported to deliver safe and effective care by the manager. All the staff told us they felt supported by the provider. Staff met with their supervisor regularly to talk about their role and people's care and support. Meetings were not planned in advance so staff did not have time to reflect on the actions of the previous meeting and plan what they wanted to discuss at the next meeting.

Staff told us they were able to raise any concerns they had about people with the manager and senior care staff quickly as they worked alongside them. Staff discussed people's needs throughout the shift and supported each other to provide effective care. An annual appraisal process was in operation.

We would recommend that the provider review the application of their staff supervision and support processes to make sure they are being followed at the service and are effective.

People's relatives told us that staff quickly identified changes in their relative's health and contacted their doctor or other health care professionals. People were supported to maintain good health. Staff contacted health care professionals when they identified a concern and followed the treatment plans they prescribed. For example, one person had been losing weight. Referrals to health care professionals had been made and their recommendations acted on. The person had gained weight and was no longer underweight.

Guidance was provided to staff about how to support some people if they became unwell. For example, guidance was provided to staff about how to keep one person's blood sugar levels within a healthy range for

them. Further guidance was provided about the signs staff may see if the person was becoming unwell and the action staff should take.

Community nurses visited some people to provide treatment for short term illnesses. People were offered regular health checks such as eye tests and a chiropodist visited every six weeks.

People were supported by staff or people who knew them well to attend health care appointments, including emergency visits to hospital or outpatient appointments. This was to support them to tell their health care professional about their health and medicines and to make sure that any recommendations were acted on when they returned to the service.

People told us they liked the food at the service and had enough to eat and drink. One person told us, "The food is very good. I get a choice, today I am having chicken nuggets".

People were able to eat their meals in different areas of the service depending on their preferences. Food and drinks were offered regularly throughout the day. Snacks were offered between meals, such as tea and biscuits, which people enjoyed. Staff offered people drinks often to make sure they did not become dehydrated. Staff knew people's likes and dislikes and offered them alternatives if they did not fancy the food they were offered.

Meals were planned to meet people's needs. People who required a low sugar diet or a reducing diet were offered the same foods as everyone else but made with sweetener rather than sugar so they did not feel they were missing out. Menus were balanced and included fruit and vegetables and homemade cakes. There was an alternative at lunchtime and several tea options which people could choose.

People who had reduced appetites or were at risk of losing weight were offered foods that were fortified, with butter and cream to provide them with extra calories. Some people were prescribed special shakes to supplement their diet. The cook also used these to fortify foods such as porridge. People knew that their foods included the supplement. People who were at risk of losing weight had put weight on.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. One person told us, "All the staff are very kind, they always help me". One person's relatives told us, "We can't fault the staff. They look after [person's name] very well". They told us that they were now confident to go away on holiday because they felt their relative was well cared for.

People and their families were encouraged to share information about their life history to help staff get to know them and provide their care in the way they preferred. This information was included in their care records. Staff knew about people's preferences, likes, dislikes and how they liked things done. Some staff knew details about people's backgrounds and life histories but this was not all recorded so not all staff were aware. This was an area for improvement.

We observed people chatting to each other in a relaxed way and people told us they always had someone to talk to. Staff knew people's preferred routines, such as who got on well and supported them to sit together at mealtimes and in the lounge. Staff showed genuine affection for people and people responded in a similar way. People were called by their preferred names. Staff spoke with people individually and in a respectful way. Staff responded quickly to people's requests, for example, to move from one area of the building to another. Staff chatted with people about things that they enjoyed and people responded. Staff treated people with kindness and people appeared relaxed in their company.

People told us staff treated them with respect. They received the individual support and attention they needed. Staff told us, they treated people as they would like their family members to be treated. We observed staff discretely asked people if they needed assistance. Staff understood what people were telling them about the support they needed. For example, one person patted their tummy when they wanted to go to the toilet.

People were treated with dignity at all times. Staff explained to people about the care they would receive before it was provided. For example, one staff member gave a person a hot drink saying, "Here's your tea, here's the handle, be careful it might be hot". Systems were in place to make sure that people's laundry did not get mixed up and items were returned to the correct person.

People had privacy when they washed, dressed and used the toilet and staff only stayed with them at their request or to keep people safe. Staff knocked on people's bedroom and bathroom doors before entering.

Personal, confidential information about people and their needs was kept safe and secure. Staff told us at the time of the inspection that people who needed support were supported by their families, solicitor or their care manager, and no one had needed to access any advocacy services.

Requires Improvement

Is the service responsive?

Our findings

People had been involved in planning their care, with their relatives when necessary. Some people were able to tell staff how they liked their care provided and told us that staff did as they requested. Staff knew what people were able to do for themselves and encouraged and supported them to continue to do this.

Before people were offered a service at High Pines their needs were assessed to make sure the staff could provide all the care they required. People and their relatives were able to visit the service before deciding if they wanted to move in.

Further assessments of people's needs had not been completed consistently once staff had got to know people more, to find out what they could do for themselves and what further support they needed from staff to keep them safe and healthy. Changes in people's needs had been identified by staff and they had changed the care they offered people to reflect the changes but had not always updated assessments and care plans.

Guidance to staff had not always been updated when changes had occurred and information was not available to help them provide consistent care in the way people preferred. For example, one person's care plan stated that the person did not require support to go to the toilet. Staff told us the person's needs had changed and they now used continence products. Information about the types of products and how to use them had not been provided to staff and there was a risk that they would not provide the person with the maximum benefit.

Detailed guidance had not been provided to staff about how to provide all the care people needed, such as how people preferred their personal care provided. Guidance was not always available to staff about what people were able to do for themselves and how they preferred their care to be provided. Staff described to us what people were able to do for themselves and how they met their needs in the ways they preferred. Staff were not confident that they all provided people's care and support in the same way so there was a risk of inconsistent care.

Some care plans had not been regularly reviewed. It was the responsibility of the person's keyworker to review their care plan with them and make changes when required. A keyworker is a member of staff who is allocated to take the lead in co-ordinating someone's care. The manager and other staff did not always make changes to the care plan when a person's keyworker was not on duty and on occasions guidance to staff about people's care was not changed.

Staff told us that they did not refer to people's care plans for information about how their care and support should be provided. Handovers were completed between shifts and brief records were kept about any changes in people's care needs. Systems were not in place to make sure that staff had accurate information about changes in people's needs and the care they required when staff returned from leave or days off. Staff relied on other staff to inform them about changes and there was a risk that important information about people would not be shared with all staff.

At the time of our inspection the provider was looking to recruit an activities coordinator and activities were provided by some care staff. We observed that some people did not take part in activities and staff did not speak to them for long periods of time. A box of activities such as musical instruments and some books was stored behind a chair in the lounge and were not easily accessible to people. One staff member told us they brought an 'activities bag' into the service "from time to time". This was not available to people during our inspection.

Not everyone was involved in planning the activities. For example, the carer doing activities on one day of the inspection told a person they had brought in a film they liked for them to watch. They put the film on and the person stated watching it and signing along. After approximately 10 minutes the staff member moved the person to another room to do another activity. Later on they returned to the lounge where most people were sitting and asked one person if they would like music on rather than the film, this person said yes and the film was switched off. Another person was watching the film but they were not asked if they were happy for it to be turned off. They did not want to sing along to the music and fell asleep.

The registered manager had failed to carry out with people an assessment of their needs and preferences and plan their care to meet these. This is a breach of Regulation 9(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were confident to make complaints about the service. A process was in place to receive and respond to complaints. Information about how to make a complaint was available to people and their representatives. The manager and staff supported people and their representatives to raise concerns or make complaints about the service. No complaints had been received in the past year. People and their relatives had paid the staff compliments. These included, 'Thank you very much for looking after [person's name]. Your patience and dedication will be remembered'.

Staff recognised when concerns were raised and took action. They told us that any concerns raised were addressed immediately. Action had been taken to address day to day concerns or worries to people's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was managing the service on a day to day basis. Staff told us the manager did not provide them with the strong clear leadership they wanted. The registered provider had recognised that the manager needed support to develop their leadership skills and was providing them with regular support and guidance.

People and their relatives told us that the provider visited the service often and they all knew him and his family. We observed people chatting to the provider in a relaxed way during our inspection.

The provider had a clear vision about the quality of the service they required but this did not always "filter down". Staff told us the manager had not always provided them with resources, such as equipment, that they needed. The provider told us, "If staff need things, I make sure they have them". Staff confirmed that the provider always gave them the resources they needed and that these were of a good quality.

At the time of our inspection the provider was in the process of updating their statement of purpose to make sure it was current and informed people, their relatives and staff about the quality and philosophy of service at High Pines. The provider strived to ensure that values including respecting diversity and independence underpinned the service provided by staff each day.

Staff felt supported by the provider. Some staff felt supported by the registered manager but other staff said they not feel supported or valued. A system was in place to allocate staff specific duties and was completed by the senior carer at the beginning of each shift. On occasions the manager changed this without consultation with the shift leader and important tasks were left unallocated. This put pressure on staff to complete extra work and some tasks were not completed, such spending time with people and record keeping.

Staff were motivated by the people living at High Pines and enjoyed supporting them. Several staff told us they "loved" supporting the people living at the service.

Staff were clear about their roles and responsibilities. Some staff were responsible for reviewing and updating care plans each month. Not all reviews had been completed regularly. A process to check that staff had fulfilled their responsibilities was not in operation and staff could not be held accountable for any shortfalls in their practice.

Systems were in place to obtain the views of people, their representatives and staff. People and their relatives had not been told about the actions taken to address all the concerns they had raised. The process for staff had not been completed regularly. Comments staff had made about improvements to the running of the service had not been addressed and continued to be of concern to them.

Staff meetings were held approximately three times a year. Some staff had made suggestions about developments and improvements in the past but said they no longer did so, as their suggestions had not

been considered or tried. One staff member told us their suggestions were later presented as the manager's idea and this made them me feel "rubbish".

Regular 'residents meetings' were held and people who attended were given information about the service. Comments and suggestions made at the meetings had not been consistently acted on, or followed up at the next meeting to check people were happy with the action taken. People who did not attend the meetings spoke to staff on their own. These discussions were not recorded to make sure that people's comments and suggestions were acted on.

We would recommend the provider review the processes they have in operation to seek and act on feedback from relevant people, such as people who use the service, their relatives and staff, to make sure they continually evaluate and improve the service.

A process was not in operation to regularly check all areas of the care that staff provided to people. The registered manager was not aware of the shortfalls in the service found during our inspection. The provider had identified some shortfalls in the service through regular visits and had begun to take action to address these. They made a commitment during the inspection to address all the shortfalls and make sure that people received a good service at all times.

Records in respect of each person's care and support were maintained. These were not consistently accurate and complete. For example, information about people's care preferences and changes in their care needs and guidance to staff about how to deliver people's care were not always recorded. There was a risk that staff and health care professionals would not have accurate information to use when assessing people's needs and planning and providing their care.

The registered manager had failed to seek and act on feedback from relevant persons, including people and staff on the service, to continually evaluate and improve the service. The registered manager had failed to maintain an accurate, complete and contemporaneous record in respect of each person. This was a breach of Regulation 17(2)(c)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had sent notifications to CQC when they were required. Notifications are information we receive from the service when significant events happened at the service, such as a when DoLS authorisations were made.

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 RA Regulations 2014 Person-centred care The registered manager had failed to carry out with people an assessment of their needs and preferences and plan their care to meet these. Regulation 9(a)(b) .

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager had not taken action to ensure that people's medicines, including 'when required' (PRN) medicines, prescribed creams and the side effects of medicines, were managed safely at all times. The registered manager had not taken action to make sure that people's medicine records were accurate. Regulation 12(2)(g). The registered manager had failed to assess all the risks to people's health and safety and ensure that action was taken to manage those risks. Regulation 12(2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager had failed to comply with the conditions of the Mental Capacity Act 2005 Deprivation of Liberty authorisation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had failed to seek and act on feedback from relevant persons, including people and staff on the service, to continually evaluate and improve the service. The registered manager had failed to maintain an accurate, complete and contemporaneous record in respect of each person. Regulation 17(2)(c)(e).