H G M Mexborough

Highgrove 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?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 3 February and 5 February 2015, and was unannounced. The home was previously inspected on 5 August 2014, where the provider was found to be in breach of regulations 9 (care and welfare), 11 (safeguarding) , 21 (requirements relating to workers) and 10 (assessing and monitoring the quality of service) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We issued compliance actions in response to these breaches.

In addition, two compliance actions had been issued at the inspection prior to this, on 21 May 2014. These were in relation to breaches of regulations 17 (respecting and involving people who use services) and 22 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Part of this inspection looked at whether improvements had been made in relation to these six breaches of regulations.

Highgrove Care Home is a 78 bed nursing home, providing care to older adults with a range of support and care needs. At the time of the inspection there were 47 people living at the home.The home is divided into four discrete units.

Summary of findings

Highgrove Care Home is located in Mexborough, a small town in Doncaster, South Yorkshire. The home is known locally as Highgrove Manor. It is in its own grounds in a quiet, residential area, but close to public transport links.

At the time of the inspection, the service did not have a registered manager, although it was required to do so. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

During the inspection people told us, or indicated, that they didn't always enjoy life at the home. Staff were observed to be very task-oriented and did not have time to spend with people beyond carrying out care tasks. There were limited activities taking place, and often peope were not interacted with.

We found that monitoring and quality assessment arrangements were insufficient to ensure people were cared for safely or in accordance with their needs. This included the management of people's care and their medication. Where changes to people's needs were apparent, they were not always appropriately acted upon.

Where people lacked the mental capacity to make decisions about their care and welfare, the correct legal procedures were not followed. Where there was a risk that people were being deprived of their liberty, appropriate assessments were not being made.

We found the provider did not have effective systems in place to ensure people's safety. Risk assessments were lacking in detail or didn't cover all areas of risk that people were vulnerable to. Restraint was not always practised legally, and we identified incidents during the inspection that we notified to the local authority's safeguarding adults team.

We are taking enforcement action against the provider, and will report on this when it is completed.

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?
The service was not safe.

Risk management procedures within the home were inadequate, and staffing was not deployed in sufficient numbers to keep people safe. Standards of hygiene within the home were poor, and the arrangements for managing medicines were not robust.

Inadequate

Is the service effective?
The service was not effective

The arrangements for obtaining and acting in accordance with people's consent were poor, and assessments to look at whether people were being deprived of their liberty had not been undertaken.

Inadequate

Is the service caring?
The service was not caring

Many of the people we spoke with told us they were unhappy at Highgrove Care Home, and we observed some people to be unkempt and not well groomed. Interaction between staff and people using the service was limited, and people did not always receive the care and support they needed.

Inadequate

Is the service responsive?
The service was not responsive

Activities within the home were limited, and the provider did not always respond effectively to people's changing needs. Complaints were not responded to in an adequate manner.

Inadequate

Is the service well-led?
The service was not well led.

The home had not had a registered manager for over a year, and management turnover had been high, having a negative impact on staff. The quality of service was audited regularly, but the audits were ineffective meaning that poor or dangerous care was not identified or addressed.

Inadequate

Highgrove 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.

The inspection was unannounced, which meant that the home's management, staff and people using the service did not know the inspection was going to take place. The inspection visit was carried out over two days; 3 February 2015 and 5 February 2015 2015. The inspection was carried out by two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spoke with ten staff, the home's manager, a senior member of the provider's management team, five relatives of people using the service, and 14 people who were using the service at the time of the inspection. We also checked the personal records of ten of the people who were using the service at the time of the inspection. We checked records relating to the management of the home, team meeting minutes, training records, medication records and records of quality and monitoring audits carried out by the home's management team and members of the provider's senior management team.

We observed care taking place in the home, and observed staff undertaking various activities, including handling medication, supporting people to eat and supporting people to participate in activities. In addition to this, we undertook a Short Observation 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 also contacted the local authority to gain their view of the service provided and spoke with two visiting professionals.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR) This 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. The provider told us they did not receive this request. We also reviewed records we hold about the provider and the location, including notifications that the provider had submitted to us, as required by law, to tell us about certain incidents within the home.

Inadequate

Is the service safe?

Our findings

We asked people using the service about how staff kept them safe from harm. One person we spoke with had bruised arms. They said: "I like to go outside for a smoke and I knock my arms on the door." We asked a senior member of staff about this, but they told us there was no risk assessment in place in relation to keeping this person safe from harm. We asked them to address this immediately, and seek medical advice. We saw on the second day of the inspection that they had completed this.

We observed a meal taking place in the home, and saw one person was taking food from another person's plate. A staff member intervened and grabbed the person's arm forcefully, raising their voice and saying: "Just stop it. Get your own dinner." This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We made an alert to the local authority's safeguarding adults team in relation to this incident.

We asked people using the service about whether there were enough staff available. Every person that the expert by experience interviewed said there weren't enough staff. One said: "They are always short staffed. They keep cutting hours all the time. Sometimes there is only one carer working. The good people have all left for better jobs."

We spoke with relatives of people using the service, who gave us a varied view about staffing numbers. One said: "They are short staffed sometimes but the staff do a very good job." However, another told us that there were always staff available and hadn't felt the home was ever understaffed.

We asked members of the home's management team about staffing numbers. We noted that, compared to the numbers of staff on duty when we inspected the home in August 2014, there had been a reduction in numbers. We asked to see any formal analysis behind the decision to cut staff numbers, but nothing was available. During the inspection, we asked the home's manager whether there were enough staff to support a specific person. They replied telling us that they had "asked the staff" what they thought. They did not consider carrying out a formal assessment until we asked them to do so.

Staff we spoke with said that they did not feel there were enough staff on duty. One staff member became upset when speaking about this. Another said that staff did not have the opportunity to take breaks. One told us that they were "sometimes" able to have lunch when working, but not always. In our observations we saw that staff moved quickly from task to task, and did not have time to engage with people. One staff member told us: "They keep asking me to increase my hours but I already do 44 hours and that's enough. I don't mind hard work but I can't do any more." This was a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that staff had received training in the safeguarding of vulnerable adults, and staff we spoke with confirmed that they understood their responsibilities. However, a senior member of staff did not have an adequate understanding of safeguarding arrangements. During the course of the inspection we identified four incidents where we suspected abuse may have taken place, but when we fed this back to the home's management team, they did not suggest that these incidents should be referred to the local authority's safeguarding adults team. A CQC inspector made these referrals after the inspection. This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment procedures were sufficient to ensure that people were kept safe. Policy records we checked showed that all staff had to undergo a Disclosure and Barring (DBS) check before commencing work, in addition to providing a checkable work history and two referees. We checked recruitment records which showed that this policy was being adhered to.

Two people using the service, and one staff member, told us that the nurse call alarms did not all work. When people with restricted mobility need to summon staff support, the nurse call alarms are how they would do this. If the alarms do not work, people are at risk of harm as they may not receive the assistance they need. We asked members of the home's management team when these were checked. They told us that they were serviced annually by an external

Is the service safe?

contractor. We looked at the service records from the last service, 12 months earlier. They stated: "Older building system is unfit for use, a system upgrade is recommended." The provider's regional manager told us that this record did not mean that the system was unfit for use. They said that the system had not been upgraded. During the inspection, the home's maintenance person commenced a series of checks of the nurse call bells. We looked at the report of the checks when approximately half had been checked. The report showed nurse call bells were not working in five of the bedrooms checked. The regional manager told us that these bedrooms were not in use, but there was no record of the fact that these rooms were not to be used.

We looked at the risk management arrangements in place for people using the service, to check that the provider's systems protected people against the risk of abuse or unlawful restraint. One person's file showed that they had bedrails in place. Bedrails are a form of restraint, used to reduce the risk of falls. Their file contained an undated form which indicated that they had consented to the use of bedrails. They had signed the form. The file also contained a mental capacity assessment relating to bedrails. This assessment concluded "On the balance of probability, the service user lacks capacity to make this decision at this particular time. Sign and date this form and proceed to consider best interests." As the person had given consent to bedrail use, despite that assessment concluding that they did not have capacity to do so, this meant restraint was not being used legally and the arrangements in place to protect people had failed to identify this practice. This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked another person's file. In our observations we had observed that staff had physically restrained this person, moving them into another area of the home. Their file contained no information about how and when they could be restrained. We asked a senior staff member about whether the person was restrained and they replied: "We have to steer [the person] away, we just do what we have to." The staff member said that the staff team had not received training in relation to restraining. The systems in place had failed to recognise that restraint was being used unlawfully. This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Another file we checked showed that the person received a specific therapy that presented risks to themselves and other people using the service. There was a risk assessment in their file in relation to this. However, the risk assessment did not set out the risks that the person was exposed to, and was not therefore effective in keeping them safe from risks. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The arrangements in place to ensure that people's medicines were safely managed were not robust. Medication was securely stored, although records of the temperature of the medication storage room were not kept, and on one occasion we observed the medication trolley to be insecure without staff in attendance. We checked records of medication administration and saw that these were not always appropriately kept; we found that a staff member had hand written an item of medication onto one person's medication administration record (MAR) but there was no signature or witness to ensure that this was accurate, and some medication was being administered without being signed for. Bottles of liquid medication did not always have the date they were open recorded, and some medication stock did not tally with the records. This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the cleanliness of the premises, and found that in some areas there was a considerable amount of damage to door frames and handrails, meaning that they could not be cleaned to a hygienic standard. One unit within the home was observed to be extremely malodorous. The home's manager asked one of the domestic staff to address this although this did not rectify the issue and the foul odour remained through the rest of the inspection. A visiting relative told us they had concerns about the cleanliness of one area of the home. We checked this area and found equipment and work surfaces to be dirty.

During the inspection, one person using the service was observed to urinate on the floor in a lounge area. Staff were present, but none began to clean the area for 15 minutes,

Inadequate

Is the service safe?

during which time another person was given a snack to eat while sitting next to the puddle of malodorous urine. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

We asked people using the service about the food available to them at Highgrove Care Home. They told us they enjoyed their meals. One person's relative told us that the food always looked plentiful. We observed lunch taking place on the first day of the inspection. We saw that everyone in the dining room we observed had hotdogs and orange cordial. We asked the home's manager whether people could have chosen an alternative. They told us that everyone had chosen to have hotdogs, however, they said people should have been given a choice of hot and cold drinks, whereas in our observations orange cordial was placed in front of each person without staff checking that this was what they wanted. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us they had waited a long time for a drink on the morning of the inspection. They said: "They [staff] got me up at 8 o'clock this morning and told me they'd be back in ten minutes. It was half an hour before they came. I got my breakfast at about quarter to ten." We asked the person whether they had been given a drink but they replied: "No, only a drop of water with my tablets." This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how effective the provider was at communicating with people using the service and their relatives. One visiting relative said: "[If there are] any concerns, they give me a ring…I ask if there are changes and they are good at communicating." However, another visiting relative said: "Some staff have an attitude problem. They know I'm not happy about how they are treating [my relative] so some of them don't even talk to me." People using the service told us that they didn't always know what was happening in relation to their care. One said: "Nobody tells me anything. People come in and out and I don't know who any of them are." They went on to tell us that there had been some changes in relation to the funding they received for their care. They were worried about this as they didn't know if it would have any impact on the care and treatment they received. They told us that the changes hadn't been explained to them. Another person told us that there was nothing to do at the home, saying: "If they do anything it's painting or stuff like that. Nothing that I would like." This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked whether people had given appropriate consent to their care and where people did not have capacity to consent, whether the requirements set out in the Mental Capacity Act 2005 had been adhered to. The Mental Capacity Act 2005 sets out how to act to support people who do not have the capacity to make a specific decision, and also sets out the legal framework in which a person who lacks capacity can be deprived of their liberty.

We looked one person's file and found that they had a mental capacity assessment which concluded that they were resistant to receiving care, and did not have the capacity to consent to receiving care. Their file contained no evidence that any decisions relating to their care had been made in their best interests, in accordance with the Mental Capacity Act. A second person's file showed that they lacked capacity. Their records showed that they had received an influenza vaccination, but there was no evidence that this had been done in the light of a best interest decision. Another person's file contained information stating that they had been assessed as lacking mental capacity when they were in hospital several months earlier. Their mental capacity had not been reassessed since they were admitted to the home. Mental capacity can fluctuate, particularly during periods of ill health, so it was not clear that this person's mental capacity assessment remained valid.

On the first day of the inspection, a senior staff member was in charge of the home until the home's manager arrived. We asked the senior staff member whether anyone using the service was subject to an authorisation to deprive them of their liberty, in accordance with the Deprivation of Liberty Safeguards (DoLS). The senior staff member told us that no one living at the home was subject to DoLS. When the home's manager arrived, they told us that one person was. This meant that the person who had been in charge of the home earlier was not aware of the legal status of the people they were responsible for.

In our observations, we saw that one person was under almost constant staff supervision, was not able to leave the

Inadequate

Is the service effective?

home if they wished, and lacked mental capacity. We asked the home's manager whether they considered that this person was being deprived of their liberty. They agreed that they might be. We asked what assessments had been done to ensure that where people were being deprived of their liberty an appropriate authorisation had been sought. The home's manager said that they could look at "a couple every week." This timescale did not address the risks of people being unlawfully deprived of their liberty with sufficient urgency. This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff about the training they had received. One said: "I've had all the training…It's all that on line stuff. I've done all of that." Another said that they felt there had been more training available over the past few months than there had previously been. We checked the provider's training records and saw that the vast majority of staff had received relevant training, including safeguarding, moving and handling, infection control and health and safety. The provider's regional manager told us that emphasis had been put on staff training and they felt this had been effective.

Inadequate

Is the service caring?

Our findings

People gave us a varied picture of their experience of Highgrove Care Home. The expert by experience interviewed 12 people, and in most cases they told us they were unhappy. One person told us: "I hate it here… it's gone down since I first came." Another person told us they were happy, but were not able to tell us anything they liked about the home. One person was in bed and told us that staff had left them in a position they were uncomfortable in. Due to limited mobility they were unable to make themselves more comfortable and their nurse call alarm had been left out of reach. This meant they had not been able to summon help until a member of the inspection team went into their room.

Another person told us: "They often leave the buzzer [the nurse call alarm] where I can't reach it and then I have to shout for help at night because I can't walk. When they come they shout at me and say I'm waking everybody up. I don't like waking people up but I have to shout if the buzzer's not there." We checked this person's daily notes in their care plan. They included an entry which stated "very nasty toward staff did not want to go to bed early tried to explain why but [the person] just got very nasty shouting saying we should leave…" We asked a senior staff member about this, but they said they did not know why the person was being put to bed against their wishes.

Several of the people we observed were not in clean clothes, and some of the men were unshaven. We observed one person sitting in a lounge area for a morning with food crusted around their mouth, and another who had been left with a soiled napkin around their neck for over half an hour after finishing their breakfast. One visiting relative told us that their relative had not been supported to have a bath for the first five weeks that they were at the home.

When we observed care taking place in the home, we observed incidents where staff did not attend to people's needs in a timely manner. For example, one person was gesturing in a way which indicated they may have wanted to use the toilet. Staff did not attend to support them, and after a short while they were incontinent. Another person asked staff for a drink. Staff did not provide the drink until a member of the inspection team intervened after 25 minutes had passed. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We carried out a Short Observational Framework for Inspection (SOFI) during one morning period. Throughout the SOFI, we noted that staff interactions with people were not meaningful, and predominantly consisted of staff asking people if they were all right when passing them. We did not observe any staff stopping to listen for an answer when they asked this. People we observed sat passively in the room, or were sleeping. The times when staff did interact with people it was to carry out tasks, such as taking people to the toilet or giving people their medication.

We looked at how the provider responded to people's requests. We found that one person had asked staff, two months prior to the inspection, to obtain adapted cutlery to assist them in eating. We asked a senior staff member whether this had happened. They checked and told us that this request had been "forgotten," so the person had not yet received the equipment they needed to improve their day to day life. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

In two lounges we observed, people were sitting in front of TVs. The TV in one area was playing very loud pop music. A member of staff came into the room, commented that the TV was too loud, and turned it down. The staff member did not consult with the person in the lounge about whether they wanted the TV on at all, or what they would prefer to watch. In another lounge, five people were sitting in front of a TV which was showing a discussion programme. The topic under discussion was of a highly sexual nature. We asked two people whether they wanted to watch this programme. One answered "no" and the other described the programme saying "what a carry on." None of the staff who were coming in and out of the lounge asked people whether they were happy with what was on the TV, or whether they wanted an alternative programme.

We observed two people in a third lounge area. One was asleep and the other was agitated and tearful. There was a TV playing in the corner of the room but it wasn't tuned in properly and the picture was 'snowy' and jumping. We heard a staff member say "that TV never works properly" and walk past. The staff member did not interact with the two service users or take action to improve their entertainment or activity options.

We saw that activities were taking place in the home, however, the home consisted of four discrete units, and employed one activities coordinator. This meant that activities were only taking place in one of the four units at any one time during the inspection. People we spoke with told us that occasionally they were taken out for shopping trips, but could not describe any other external activities. Men using the service told us there were no activities of interest to them. In the lounge where we saw a craft-based activity taking place, people indicated that they enjoyed this, and there was a positive atmosphere in the room. Some people told us there was little to do, although they praised the activities coordinator.

We asked two staff about the activities available. They told us that activities were available, however, they emphasised that the workloads of care staff meant that they rarely had time to undertake activities with people.

We asked a senior staff member about the arrangements for people's friends and relatives visiting the home. They told us that visits were welcome at any time, and said that relatives enjoyed visiting. One relative we spoke with said: "The greeting makes you feel welcome." However, another said they were not made to feel welcome and that staff did not offer them a drink.

We checked care records, and found that the provider was not always responsive to people's changing needs. For example, one person's care records showed that they had a pressure sore two months earlier which had been treated by a tissue viability nurse. However, their skin integrity had not been assessed since before that date. The same person had recently had an agreement put in place stating that cardio-pulmonary resuscitation should not be attempted (commonly referred to as a "DNAR") but their care plan relating to end of life did not reflect this. The care plan had been updated since the DNAR had been put in place, but the reviewer had recorded that there were no changes to the person's end of life needs, which was incorrect. Another person had been referred to a physiotherapist some months earlier, but there was no evidence that they had yet been seen by the physiotherapist. There were no notes in the file to evidence that staff had followed this up or checked on the progress of the referral. The home's manager said that they had checked on this, but this was not recorded anywhere.

We saw in one person's file, their records showed that they had lost approximately one third of their body weight in the preceding six months. Their care plan, written five months earlier, stated that if they continued to lose weight, they should be referred to the dietician. This referral had not been made so we asked for it to be made urgently. Another person's records showed that a community psychiatric nurse had requested that they receive a specific type of support every day. We checked their file and found that this support had not been provided for over a month. One visiting relative told us they had asked for their relative's toenails to be cut. They said: "A couple of days later I asked again and they told me that the chiropodist had been but they had forgotten."

Another person's care plan indicated that they should be weighed every week if they lost weight. We saw that they had lost weight but weekly weights were not being recorded. One person's care plan described that they benefited from social activities and engagement with other people, however, the only activities described in their notes for the previous two months were four occasions of having their nails painted. Another person had a care plan in their

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Is the service responsive?

file stating that they had a specific health condition. There were records where staff had recorded their observations in relation to this health condition. We asked a senior staff member about this. They told us that the person did not have this health condition and the care plan was there in error. We asked why staff were recording incidents of ill health when they were not occurring, but the senior staff member did not know. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was information about how to make complaints in the form of a complaints procedure which was also contained in the service user guide. The complaints procedure did not give people accurate information about who they could complain to if they were unhappy with the provider's internal complaints processes.

We looked at records of complaints. We noted that one complaint had been made by a staff member to the home's manager. The manager passed the complaint to the regional manager to be investigated. We asked the regional manager about this. They told us that they had passed the complaint back to the home's manager for investigation. There was no evidence in the complaints file, or the records of the staff member concerned, to show that this complaint had been addressed. One relative told us they had complained to staff about clothes going missing, but they said this had not been resolved. We raised this issue with the home's manager during the inspection, and the clothes were found. The provider had failed to act appropriately when the complaint was first received. This was a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We asked people using the service about the management of the home. One said to us: "There have been a lot of them." Another told us the current manager was "very nice."

We looked at the arrangements for involving people in the way the home was run. A meeting for people using the service had taken place in October 2014, where discussions were held about food and activities. One person's relative told us that they felt they could give input and make suggestions with regard to the way the home was run, but people we spoke with told us that staff made decisions about these matters.

The home was required as a condition of its registration with CQC to have a registered manager, but did not have one. The last registered manager had left in 2013, although the provider had failed to notify CQC of this. There had been three managers in place since then, but none had applied to register with the Commission. The manager in place at the time of the inspection described themselves as an acting manager, and they had been in post a few days when the inspection took place. They had managed the home on another ocassion in the previous year.

We asked the manager what progress was under way to achieve the requirements of the six compliance actions that had been issued as a result of the previous two inspections. They said: "As far as I am aware, they are compliant, there are things they are trying to improve on."

We checked the audits carried out by the regional manager. The regional manager told us they took place every three months, although a record of the most recent one was not available. The audits did not look at what steps the home was taking to meet the requirements of the compliance actions, so it was not clear how the provider could assure themselves that appropriate action was being taken to achieve compliance.

Quality audits had been carried out by the home's manager and staff, however, they were not effective. For example, medication was audited regularly, but the audits had failed to identify that checks weren't carried out on the temperature that medicines were stored at, or that bottles of liquid medicines did not always have their opening date recorded. Likewise, an audit of the premises was regularly undertaken, but it did not identify or address the fact that some nurse call bells weren't working.

We checked audits of care plans which showed that care plans were regularly audited for quality and accuracy. They had been checked in December 2014 and January 2015. However, we identified a large number of errors and omissions in care plans, indicating that the audits were ineffective. For example, one care plan in relation to nutrition stated that they should be weighed weekly, but this was not taking place. Their records showed that they had lost 6 kg in weight in a three month period, but their nutritional screening tool had not identified this. Likewise, another person had lost over 20 kg of weight but again their nutritional screening tool did not record this. A third person had a risk assessment in their file that did not set out the risks that they were exposed to, and another person's file contained a health care plan which a senior staff member stated was not relevant to them as it described a health condition which they did not have. None of these inaccuracies or omissions had been identified via the home's auditing system. This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about leadership at the home. All the staff we spoke with told us that they had found the turnover of managers difficult, although some praised the current manager. They told us that they received regular supervision with a line manager, and the personnel files we checked reflected this. The nursing staff we spoke with told us that they had not received clinical supervision. Clinical supervision is an opportunity for nurses and other clinicians to review their practice and reflect on cases in depth. One senior member of staff told us they didn't know if they had received supervision or clinical supervision.

Staff told us that team meetings took place regularly, and records we checked confirmed this. Team meetings were used to communicate developments within the home, and discuss and agree methods of working. In addition to team meetings, one of the home's managers over the previous year had held weekly "manager's surgeries" which were an opportunity for staff, people using the service and their relatives to meet informally with the home's manager. Records indicated that some staff and visitors had utilised this, however, the records also showed that they had stopped taking place a few months before the inspection.