D.M. Care Limited

Highbury House Care Home

Inspection report

580-582 Lytham Road
Blackpool
Lancashire
FY4 1RB

Tel: 01253344401
Website: www.blackpoolcarehomes.co.uk

Date of inspection visit:
12 August 2019
13 August 2019
16 August 2019
19 August 2019
22 August 2019

Date of publication:
02 October 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Highbury House Care Home is a residential care home providing personal and nursing care to 19 people aged 65 and over at the time of the inspection. The service can support up to 28 people. The property is a large detached house with accommodation over two floors. There is a passenger lift for ease of access and the home is wheelchair accessible. Most of the bedrooms are single occupancy and en-suite.

People's experience of using this service and what we found
There is a history of non-compliance. The provider representative had failed to respond adequately to serious concerns raised by CQC and improve the care people received. The auditing and governance systems failed to identify or address the concerns raised during the inspection or no action was taken to give oversight of the service being provided. There was a lack of stability in the management team. The provider representative failed to display their rating on their website.

People were at risk of avoidable harm. The provider representative had failed to sustain an environment where infection prevention risks were monitored and reduced. Medicines were not managed safely. There was a lack of oversight on stock control, storage, administration and governance. Good practice guidance on risk management was not consistently followed.

The provider representative did not always follow good practice guidance to ensure robust recruitment procedures were followed. We have made a recommendation about this that can be seen in the 'safe' section of this report.

Staff did not always use positive language that promoted people's individuality. We have made a recommendation about this that can be seen in the 'caring' section of the report.

We received mixed opinions on people being supported to express their views and being involved in decisions about their care. Initial assessments involved people and their relatives. However, people and their relatives were not always involved in follow up reviews.

People's dignity was not always promoted. Everyone received their meals and drinks on plastic plates and in plastic mugs. We have made a recommendation about this.

We observed positive interactions between staff and people who lived at the home. People were comfortable in the company of staff and looked forward to staff coming on shift. One person told us, "They [staff] are very nice, not snappy."

The provider representative had introduced task orientated routines which were not always liked by people living at the home. We have made a recommendation about this.

People's care plans held information on their history, likes and dislikes. Communication strategies were in place, however one person required information adding to guide staff how to support them when they were agitated. Families told us they were made to feel welcome. A member of management said they would provide end of life care and support people to remain at the home if that was their preferred place of care. There had been no formal complaints since the last inspection.

The provider representative did not induct new staff appropriately to ensure they had suitable knowledge and skills to meet people's needs effectively. People told us they would have liked a choice at mealtimes. We did see alternatives being offered when people declined what was presented. We received mixed feedback on how the provider representative liaised with other agencies to keep people healthy. Visiting health professionals were complimentary on how the provider representative was managing one person's health condition. We were also made aware that one person was hospitalised due to the management team, at the time, failing to seek timely medical support.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 17 October 2018). The provider representative completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection improvement had not been embedded and sustained and the provider representative was still in breach of regulations.

Why we inspected
The inspection was prompted, in part, due to concerns received about the leadership and management of the home, the management of medicines, staffing and good governance. A decision was made for us to inspect and examine those risks.

Concerns were also received following a specific incident, where a person using the service sustained serious injuries. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident. The information CQC received about the incident indicated concerns about the management of infection prevention, unsafe medicines management and a failure to liaise with health professionals.

We have found evidence that the provider representative needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well-led sections of this full report.

You can see what action we have asked the provider representative to take at the end of this full report.

The provider representative is working with the local authority to mitigate risk. They have sought alternate medicine suppliers in response to concerns identified, engaged in staff recruitment and are reviewing the leadership and governance of the service.

Enforcement
We have identified breaches of the regulations in relation to the failure to provide safe care and treatment for people and the failure to have effective governance including assurance and auditing systems or

processes in place.

A Notice of Decision to vary a condition on the provider's registration was served. They were no longer authorised to carry on the regulated activity, 'Accommodation for persons who require nursing or personal care' from Highbury House Care Home, 580-582 Lytham Road, Blackpool, Lancashire, FY4 1RB.

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.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Highbury House Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider representative was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector and one pharmacist medicines inspector on the first day. On days two, three and five the inspector returned to the home alone. The inspector telephoned relatives on day four for their feedback on the service provided.

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

The service did not have a manager registered with the Care Quality Commission. The previous registered manager had left on 02 July 2019. It was unclear if the service had a manager. The provider representative identified the senior carer as the manager. The senior carer disputed this stating they were going to remain as a senior carer.

Notice of inspection
This inspection was unannounced on the first and fifth day.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, this included information related to a specific incident that is under investigation. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider

representative was not asked to complete a provider representative information return prior to this inspection. This is information we require provider representatives to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service, five relatives and three friends of people about their experience of the care provided. We spoke with twelve members of staff including senior carers, carers, cooks and an activity co-ordinator. We spoke with three staff members from another home owned by the provider representative who were working at Highbury House Care Home. We spoke with two agency carers, six visiting health and social care professionals and the provider representative who is also the nominated individual.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at a variety of records relating to the management of the service and walked around the building to make sure it was a clean and safe environment for people to live in.

After the inspection
We continued to seek clarification from the provider representative to validate evidence found. We attended a meeting with the local authority to share the evidence from the inspection and review the information they had gathered from recent visits to Highbury House Care Home.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection
At our last inspection the provider representative had failed to provide and maintain a clean and appropriate environment that enabled the prevention and control of infections. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the following issues support a continued breach of regulation 12.

- There were no up-to-date environmental audits to ensure the home was clean. One carer said, "None of these have been done we were prioritising meeting people's needs." We looked at records that indicated the mattress audit had not been completed since November 2018. We checked three mattresses to ensure they were clean and fit for purpose. We found one mattress did not have a cover and was ingrained with stains from faecal matter. This left the person at risk of contracting an infection through poor infection prevention measures.
- The fridge used to store medicines was unclean and a box holding a prescribed medicine was stuck to the floor of the fridge. The senior carer cleaned the fridge when it was brought to their attention.

Using medicines safely

- Medicines were not managed safely which placed people at risk of harm. The records about medicines were incomplete and inaccurate so they could not provide evidence that medicines were given safely.
- We found two people were given the wrong doses of their medicines because of poor record keeping.
- Staff did not always know what creams and inhalers people were prescribed. This meant people were not always given their creams and inhalers as required. We found a prescribed cream from 2017 in one person's bedroom. The label on the cream indicated the cream did not belong to anyone currently living in the home. The provider representative and two staff members did not recognise the name on the cream bottle.
- We looked at how medicines were stored. We found some medicines in drawers in a filing cabinet in the office which were not accounted for.
- The provider representative did not have risk assessments to make sure that people could look after their own medicines safely, when they chose to do so.
- We found people were at risk of being given doses of some of their medicines too close together or at the wrong times because the provider representative's systems did not include checks to make sure this did not happen.

Assessing risk, safety monitoring and management

● There was no consistent oversight to manage the risk of people getting pressure sores. People had pressure relieving equipment such as mattresses and cushions. The provider representative told us it was the cleaner's responsibility to manage this equipment. The cleaner said it was not part of their role stating, "Don't give me extra jobs." The senior carer told us the carers should manage the equipment. We looked at the equipment and found two cushions needed inflating, one mattress needed inflating and one mattress needed to be placed on one person's bed.
● We look at people's Waterlow scores. Waterlow scoring is a way to assess changes in people's risk of developing a pressure ulcer and allows the home to take appropriate action. The provider representative did not ensure these were up to date. The information we reviewed indicated 16 people required their Waterlow assessment updating. The senior carer confirmed people's assessments needed updating.
● The risk related to people's nutritional needs was not consistently safely managed. We read a dietary requirements / dislikes sheet displayed on the kitchen wall that identified two people required a modified diet to protect them against malnutrition or the risk of choking. Through observations and looking at documentation, we found five examples where the dietary requirements / dislikes sheet guidance had not been followed and this had put people's health at risk.
● The provider representative did not ensure the environment was secure to lessen risk and keep people safe. One person had previously left the home unsupported. The provider representative had put lawful restrictions in place to keep the person safe. However, on the first day of inspection the person was found alone in the kitchen. The open kitchen door led onto a yard where the gates were not secured, and the person could have left the home again unsupervised. The provider representative secured the gates when this was brought to their attention.
● Information on how to manage risk in relation to emergency situations was not regularly reviewed. People living at the home had personal emergency evacuation plans (PEEPs). A PEEP is a personalised 'escape plan' for individuals who may not be able to reach an ultimate place of safety unaided, or within a satisfactory period. However, the majority of these were not updated in line with the provider representative's policy. The senior carer confirmed this information needed updating.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse and unsafe care. Not all staff had received training to enable them to safeguard people from abuse. One staff member said they had worked at the home for two weeks and had not received training. They had shadowed staff but at the time of the inspection, were working without supervision. A second staff member who did not deliver direct care had worked at the home for five months. They had received no training related to safeguarding adults. This training helps to ensure staff can carry out their duties knowledgeably and safely and are able to understand who are at risk of harm or are particularly vulnerable. This showed the provider representative failed to ensure staff had the suitable competence and skills to deliver care safely.

Learning lessons when things go wrong
● There was no documentary evidence to indicate there were systems to show any analysis of incidents and accidents had taken place. At this inspection, we could not be satisfied that there was any learning when things went wrong. We did see one area of the home had been made safe after someone had fallen. At the previous inspection we saw accidents and incidents were recorded and actions taken to minimise risk.

The provider representative was not completing regular audits of the service. This issue forms part of a series of issues of a similar nature that have led to a breach of regulations that can be seen in the 'Well-led' section of the report.

Staffing and recruitment

● The provider representative did not consistently follow robust recruitment procedures. We looked at three staff members recruitment documentation and found two staff members did not hold a full employment history. This meant that the home was unable to be assured of the staff member's previous work history and suitability for the role.

We recommend the provider representative adopts current best practice in relation to the recruitment of all staff..

● Staff we spoke with told us they had to have relevant recruitment checks prior to their employment which included disclosure and barring service (DBS) checks. DBS checks are a way a provider representative can make safer recruitment decisions and prevent unsuitable people from working with people who may be vulnerable.
● There were times people were left alone in communal areas with no staff present. Work practices were changed when concerns were raised by a visiting local authority professional.
● People we spoke with and visiting relatives did not raise any concerns related to staffing. One person said, "They pay attention if you press your buzzer."

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The provider representative did not ensure all staff understood people's needs. There was a document available to guide staff on people's needs. This was not always given to agency staff who were unfamiliar with people's needs. One agency staff member told us, "I am just winging it."
- The provider representative had not ensured staff had the right skills and knowledge to effectively and safely meet people's needs. The provider representative therefore could not be assured people they supported were being cared for in line with safe and best practice.
- We received mixed feedback on the support people received. One person stated they felt another person at the home did not always get the time they required to have their needs met. A second person said, "They are all very helpful and look after us."

The provider representative did not ensure that staff had the competence, skills and knowledge to fulfil their role. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

- We viewed dietary records, and these did not always reflect what people had eaten or drank. One staff member documented one person had been given egg and bacon and 200 ml of tea. The person had been given egg and tinned tomatoes and the tea was still in front of the person untouched after the notes had been completed. We observed a second person being given a drink while sat in the sun room. They left the drink untouched, but the daily notes documented they had had the drink. This meant people's fluid intake could not be effectively monitored to manage their hydration needs safely.
- No menu was available for people to choose from. There was only one choice of main meal at lunchtime. People told us they did not always have a choice around what food they had to eat. We did observe people being offered alternate choices if they did not like what was provided. However, we overheard one person ask for egg on toast for breakfast. They were told to have marmalade on toast as it was close to lunchtime. One person commented, "They look after us very well foodwise."
- There was not always continuity of support for people who required help to eat their meals. One person had four different staff members during their lunchtime meal. One staff member commented, "While you are still chewing, I'll help [another person who required support.]" This left the person waiting until a different staff member helped him.
- The dining room was set with table cloths and napkins. People could choose where to eat; either in their rooms, remain in the lounge or the dining room. We overheard one person arranging with a staff member

that they sat with their friend at lunchtime.

We recommend the registered provider representative review people's mealtime experience and inform people of their planned meal and alternatives before each mealtime.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The inspection was prompted, in part, by notification of a specific incident which indicated the registered manager, who is no longer in post, did not always seek medical treatment to keep people healthy. We are unable to make an informed judgement until the investigation into the specific incident is concluded.

● There was evidence the provider representative had liaised with local health professionals to ensure people received the required support to manage ongoing health conditions. A visiting community health professional told us they had no concerns related to the service managing one person's ongoing health condition.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● The present inspection was prompted by information of concern related to the safe care and treatment of people living at the home. Evidence found shows the provider representative was not always working in line with standards, guidance and the law.

● The provider representative assessed people's needs before they moved to Highbury House Care Home. However, most of the care plans needed updating. This was confirmed by a member of the management team.

Adapting service, design, decoration to meet people's needs

● We observed the corridor outside the lounge was narrower than the hoist people required to help with moving and handling. Staff had to lift parts of the hoist over skirting boards to access the lounge when they needed to meet their moving and handling needs. There was a lift between the ground and first floor to help people who could not use the stairs.

● We saw some dementia friendly signage throughout the home that promoted comprehension for people living with dementia and guided them around the home. We saw large black and white wall murals that showed bygone times. Wall murals are orientation tools, making an area distinct and memorable. Rooms were individualised with photographs and pictures from relatives and supported people's wellbeing and sense of belonging.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider representative had liaised with the local authority to ensure they had the legal authority to

deprive persons of their liberty. We observed one person receive a visit from their appointed representative to review their restrictions in place. However, the security of the building was not safe. On the first day of the inspection we found the gate in the back yard had a quick release button that was accessible and would allow people access to the main street. The provider representative secured the gate as soon as it was brought to their attention.

● At the last inspection, we saw the registered manager had reviewed all the care plans and had obtained written consent from people or their representatives to indicate consent to care was sought in line with guidance and legislation. At this inspection staff could not find consent forms for us to review.

● We received mixed messages about people's involvement in the review of their care with only one relative telling us they had attended review meetings.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

● The provider representative did not always promote people's dignity and independence. We observed people's mealtime experience. We saw everyone, regardless of their abilities, was served their meals on yellow plastic plates and received drinks in yellow plastic mugs. We asked two members of the management team why everyone had plastic crockery. They were unable to say why this was in place. One person required a plate guard to help them eat independently. This was not always provided.

We recommend the provider representative follow good practice guidance on person centred care and promoting self – esteem.

● Records indicated people were not always provided with regular support to manage their continence needs. We shared this with the provider representative who told us they would review current working practice plus there was ongoing recruitment to provide additional staffing.

Ensuring people are well treated and supported; respecting equality and diversity

● The provider representative did not ensure people were always treated well and respected. Staff sometimes used language that reflected the support they required and not the person. For example, when people required two staff to support them with their personal care, they were referred to as, "Doubles." When people were unable to eat without support, staff talked about 'feeding' people, [not in front of the person].

We recommend the provider representative follow good practice guidance on the use of positive language within a care environment.

● We observed many positive interactions between people and staff, however these were mostly when staff were providing support. We also observed people were comfortable in the company of staff and actively engaged in conversations. We overheard staff talking with people about subjects they valued and enjoyed discussing. The staff members chatted using language people understood and could respond to.

● People's care records contained information about people's background and preferences, and contracted staff were knowledgeable about these. We observed staff ensured that people who had formed friendships sat together in the lounge and in the dining room. One person told us, "They see that you are comfortable and if you want anything." One relative commented, "The staff are caring."

Supporting people to express their views and be involved in making decisions about their care

● We received mixed views on people being supported to express their views and being involved in decisions about their care. A member of management told us people were not always included when care plans were reviewed but were involved when care plans were first written. One relative told us, "[Family member] seems to be happy, never had any concerns. I have never been invited to any meeting with [registered manager] and [deputy manager]." A second relative commented, "[Family member] has had reviews and they are fine."

● The provider representative supported people to access advocates, these are independent people who support people to ensure their rights and best interests are being protected. An advocate visited one person while the inspection was taking place. The member of management on duty ensured they had access to all relevant documentation.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The management team at the time completed an assessment of people's needs before they could move into Highbury House Care Home. However, at the time of the inspection, three people lived at the home who required a high level of support or oversight. The local authority as part of their risk management strategy organised a review of their needs and they were moved to nursing homes.
- The provider representative had introduced routines to ensure people's needs were met. The bathing rota involved one person having to be up for 7am to have a bath. They told us, "I'm 82, I don't want to get up at that time. You don't feel like waking and being shuffled around." We read the bath rota, it read, 'All morning baths should be done between 8am and 9am while there are four care workers in the building.' A member of night staff confirmed they woke people to help them with their person care needs. The provider representative stated tasks had to be carried out when staff were available to complete them.
- The provider representative introduced two sittings at meal times to ensure people received suitable support with meals. However, people who required the most support were on the same sitting and there was not enough staff to offer everyone timely support. We noted one person had to wait until staff were available. One person told us, "The split sittings, I don't agree with it. The staff are all in a dash to get cleared up and finished." A member of staff told us the evening meal was rushed as they tried to have everything finished before the cook finished. During the inspection the provider representative had removed two sittings at mealtimes.

We recommend the provider representative review processes to ensure people receive personalised care that meets their needs and preferences.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- We saw people's communication needs had been assessed and where support was required, this had been documented for most people. However, when one person became agitated there was no behaviour management plan that guided staff on how to communicate with the person effectively. A member of management told us they would update the care plan.
- The provider representative supported people to attend scheduled appointments when they required medical support with their hearing and eyesight.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.

● Since the last inspection, the provider representative had introduced an activities co-ordinator to take the lead on providing activities within the home. However, the activities co-ordinator stated that five hours a week made it difficult to support people regularly. They also raised concerns that there was a lack of a budget to provide meaningful activities for people. One relative said, "They need more activities."

● We did see people listening to music they enjoyed. One person listened to 60's music, nodding along to the rhythm and one person enjoyed listening to opera.

● Relatives and friends told us they were able to visit anytime, and they were made welcome. We observed people, where appropriate, were supported to leave the home independently to access local community facilities.

Improving care quality in response to complaints or concerns

● The service had a complaints procedure which explained how a complaint should be made and showed how these would be responded to. The complaints procedure was advertised in the communal area of the home. It advertised the contact details of alternative organisations should people not wish to deal directly with the provider representative.

● Relatives we spoke with all said they knew how to make a complaint but had not needed to. One relative said, "I have never found anything to complain about." The provider representative told us there had been no formal complaints since the last inspection.

End of life care and support

● A member of management team was able to tell us how to access palliative and end of life care for people when it was required. If people have an illness that can't be cured, palliative care manages the pain and symptoms to make them as comfortable as possible.

● The provider representative was unable to state who had received end of life care training as training records were not available. There was no-one receiving end of life support at the time of our inspection. One staff member told us, "While it's upsetting, it is about following people's religion and beliefs."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection we found audits did not always identify the improvements that were required. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the following issues support the continuing breach of Regulation 17.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was a lack of formal engagement with people and their relatives. We asked a member of management about this. We were told they did not happen. We asked about surveys and was told they had not been completed with people or their relatives recently. We did not see any people living at the home had the opportunity to formally share their opinions and have their voice heard. We spoke with two staff members who told us there had been no recent staff meetings.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was no clear management structure. The provider representative and one member of the management team (senior carer) did not agree on the title of their role. The senior carer stated they were the senior carer. The provider representative told the inspector the senior carer was the manager which was repeatedly denied by the senior carer. There was no registered manager in post. They had left their post five weeks before the inspection took place.
- We reviewed auditing and governance systems and found they had failed to identify or address the concerns raised during the inspection. The provider representative had failed to sustain effective systems to monitor the quality of the care being delivered. The mattress audit had not been completed since November 2018. We found one person had a mattress that was stained with faecal matter. No effective environmental audit had taken place leaving the security of the building unsafe and people at risk of avoidable harm.
- We received information of concern about the management and administration of medicines. When investigated we found these concerns warranted. The medicine policy failed to provide clear guidance. Medicine and cream administration records completed by staff were inaccurate and wrongly completed. The provider representative had failed to ensure there was a safe system to monitor medicines when people went home. The provider representative did not have systems to ensure people had an adequate supply of medicines. The provider representative was in the process of changing pharmacists during the inspection to minimise the risk of medicine errors. After the change in pharmacist we saw medicine errors had continued. Two incidents where staff had failed to sign for medicine had occurred and one person's stock of medicine

was wrong.
● Records were not always updated in a timely manner. This meant that people might not receive care and treatment appropriate to their needs. The provider representative had a computerised system that highlighted when documentation needed updating. They had failed to act on the prompts displayed on the computer. There were 17 care plans that required updating. For example, one person's mobility had deteriorated, and their care plan did not guide staff on safe moving and handling procedures. A member of management confirmed the care plans needed updating.
● We saw no evidence daily records were analysed and reviewed with the appropriate action taken when concerns were identified. Records related to people's personal care needs were not always completed. Charts for two people indicated that for three days they had not received the appropriate support. There was no evidence this had been identified and placed people's welfare at risk.
● Records related to ongoing consent to care were unavailable. A member of management was not able to share documentation that showed consent to treatment had been reviewed and continued throughout the duration of the care and treatment received.
● The provider representative failed to have oversight of their website and ensure the ratings were displayed.

The above information is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider representative failed to maintain processes that would achieve good outcomes for everyone they supported. The inspection had highlighted significant concerns and a lack of stability within the management team.
● People and their relatives and friends spoke positively about the management team. Observations showed people were happy to see members of the management team. One person told us, "I love [member of management team], she is my favourite, my number one."

How the provider representative understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others
● The management team knew how to share information with relevant parties, when appropriate. They understood their duty involved escalating their concerns to outside agencies, so action could be taken.
● The management team were working with other agencies to meet their regulatory requirements. They participated in honest and frank discussions as part of the inspection process and local authority reviews of people's needs.
● Visiting health professionals told us they had no concerns related to the management of one person's ongoing health condition.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider representative failed to provide care and treatment in a safe way.

The enforcement action we took:

Notice of Decision to vary a condition on your registration. You are no longer authorised to carry on the regulated activity, 'Accommodation for persons who require nursing or personal care' from Highbury House Care Home, 580-582 Lytham Road, Blackpool, Lancashire, FY4 1RB.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider representative failed to have effective systems and processes to make sure they assess and monitor their service.

The enforcement action we took:

Notice of Decision to vary a condition on your registration. You are no longer authorised to carry on the regulated activity, 'Accommodation for persons who require nursing or personal care' from Highbury House Care Home, 580-582 Lytham Road, Blackpool, Lancashire, FY4 1RB.