Barchester Healthcare Homes Limited

High Habberley House

Inspection report

Habberley Road
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23 June 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

The inspection took place on 21 and 23 June 2017.

The home provides accommodation with personal and nursing care for up to 45 people. At the time of our inspection 20 people were living at the home. Bedrooms and communal facilities were situated over the ground and first floor. A 'bungalow' area was not in use at the time of the inspection. At the last comprehensive inspection in March 2015 the service was rated as Good overall. We rated the effective question as Requires Improvement and a breach in regulation was identified. We carried out a focused inspection concentrating on this area only in December 2015. We found the breach was met however the rating in this one area remained the same.

The rating following this inspection has changed to Requires Improvement.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The leadership of the home was not effective in recognising shortfalls to the health and safety of people who lived at the home and others. Systems in place to monitor the quality of the service were not always effective in highlighting shortfalls and identifying where improvement was needed.

Staff received training to enable them to have the skills and knowledge needed to care for people. This knowledge was not consistently put into practice by all members of staff. The care and support provided was not always personalised in order to meet the individual needs of people who lived at the home. Care practises were not always consistent with providing people with dignity and respect.

People told us they liked the food provided however people did not consistently receive the support they required.

Staff felt there were insufficient numbers on duty to enable them to provide the care and support people needed. Staff felt there was a reliance on a staffing tool and were unable to speak with us about its application. People did not have access to hobbies and interests due to a lack of staff to support them. When people needed support and used the call bell this was not always responded to in a timely way.

People received support and were able to access healthcare provision such as their doctor to maintain their wellbeing. People had there medicines administered as prescribed. Cream and ointments were not always applied in line with instructions

People felt safe at the home and liked the staff. Staff knew of the action needed in the event of them having

to report abuse or any concerns. People were offered choice and consent was obtained before care and support was provided.

We found a number of breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is Requires Improvement.

You can see what action we told the provider to take at the back of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not always able to be assured sufficient staff with the right skill mix would be available to meet their needs.

People were not always having prescribed creams applied in line with instructions.

People felt safe and secure and staff were aware of the action needed if people were at risk of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective

People were not always supported by staff who implemented all elements of their training.

People were supported with decision making which respected their rights.

People liked the food but were there were inconsistences in the support people received when eating.

People had their healthcare needs met including referrals to other professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring

People were supported by staff who were kind but there were inconsistences in the knowledge around individual needs.

People's privacy and dignity was not always respected.

Is the service responsive?

Requires Improvement

The service was consistently not responsive.

People did not always receive personalised care.

People did not always receive a timely response from staff when they used their call bell seeking assistance.

People were not able to benefit or participate in hobbies and interests due to a lack of staff to support people's wellbeing.

Is the service well-led?

Inadequate

The service was not well lead

Systems in place by the provider were not effective to identify and monitor the quality of care and the safety of people who lived at the home.

There was a lack of management oversight which resulted in poor and hazardous practices taken place.

High Habberley House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 and 23 June 2017 and was unannounced. It was completed by two inspectors on both of these days. An expert by experience joined the inspection on 21 June 2017. An expert by experience is a person who has personal experience of using or caring for someone who lives with dementia.

Prior to our inspection the provider had completed 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 intend to make. We reviewed the information we held about the service and looked at notifications they had sent to us. A notification is information about important events which the provider is required by law to send to us. The inspection considered information shared by the local authority.

During the inspection we spoke with eight people who lived at the home and six visiting relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with three care staff members as member of the catering team and maintenance person. In addition we spoke with the deputy manager and one nurse. We looked at care plans and risk assessments relating to six people plus medicine records for people. We also look at records maintained by the registered provider such as audits, minutes from meetings and complaints.

Requires Improvement

Is the service safe?

Our findings

We spoke with people about the availability of staff on duty and whether they believed the number to be sufficient to meet people's needs. The response from people was mixed in relation to the length of time people had to wait for staff if they needed care or support. One person told us, "There are enough staff" another person said the same and added, "Especially at night". Another person said, "There is a bit of a wait sometimes when I press the call bell but the staff explain if they are looking after someone else and how long they will be." A further people told us, "Sometimes it can take quite a long time for staff to respond to the call button during the day". Another person told us, "Staff come when not busy" and "I think they are understaffed. I think they need more help." We similarly received a mixed response from relatives regarding staffing levels and the availability of staff to meet the needs of their family member.

We took note during our inspection of the amount of time it took for staff to answer call bells when people who lived at the home sought the attention of the staff on duty. While we did not witness any evidence of people being placed at immediate risk to their safety we did nevertheless see a lack of response from the staff on duty and have reported upon this under the Responsive question of our report.

At the time of our inspection the activities coordinator was working as a care assistant due to shortages in the staff team. We asked staff whether they believed sufficient staff to be on duty. One member of staff told us, "We don't have time" when we spoke about how they met people's individual care needs. Another member of staff told us of the, "Struggle'" to get the work done due to staffing numbers. Staff told us of a dependency tool used to determine staffing levels and how this needed to be worked to.

On the second day of our inspection due to two members of staff reported they were unable to work their shift. The rota was covered however staff were deployed in such a way staff providing care for people needing two members of staff did not know people's basic care needs. For example they did not know whether one person needed an aid to help them hear and therefore communicate with staff.

On the afternoon of the second day of our inspection there were two male care workers and the nurse. We were told one person had elected to only receive personal care from female care staff. Staff told us 18 people out of 20 would need two members of staff to provide personal care. As a result people would need to wait until staff were available in the event of them requiring personal care and support.

Staff told us the deputy manager ensured any wounds people had were taken care of. People we spoke with told us staff cared for any wounds they had. We saw information was available to nursing staff to remind them who needed to ensure people did not develop sore skin. This information showed when dressing needed to be changed. However, we saw one person had a dressing in place. When we asked the deputy manager and the nurse on duty about this wound they were unaware of its existence and could not give us details about it. They confirmed no care plan was in place regarding this wound.

People we spoke with told us they received their medicines when they required them. One person told us, "I am on daily medication and I always get it at the same time." Another person told us staff applied cream on

their arms as needed.

We saw and staff confirmed some people were prescribed creams and ointments for example to prevent them developing sore skin. We spoke with a nurse about one tube of cream from a person's bedroom who told us it would appear staff were not applying creams as prescribed. For example the time since the tube was first used was too long ago for it still to be in use.

We saw a nurse administered people's medicines from trolleys. The nurse was seen to refer to people's records while administering prescribed items and ensured people had a drink available. Protocols were in place for the administration of medicines prescribed on an as and when needed basis. These protocols were seen to be reviewed on a monthly basis. The nurse was heard asking one person if they wanted a medicine prescribed as when needed. The person responded by saying, "Thank you for asking me". A visiting healthcare professional told us they had no concerns regarding the management of people's medicines.

We saw records regarding the administration of medicines were completed. Medicines requiring additional storage and recording were maintained accurately. The deputy manager undertook to amend the records of one person due to them having a duplicate record in place for their medicines to avoid any mistakes. Records regarding one household remedy were not accurate and the deputy manager was unable to explain how staff had recorded occasions when the medicine was used.

People we spoke with told us they felt safe living at the home. Relative we spoke with also believed their family member to be safe living at the home. One family member told us, "I definitely feel that my relative is safe here." Staff we spoke with were aware of who they could report any concerns they may have about actual or potential abuse to. One member of staff told us abuse is, "Not acceptable and I would report it straight away." Another member of staff told us, "Would not stand for it." Staff were aware of the provider's whistle blowing procedures and confirmed details of who to contact were available to them. A nurse we spoke with was aware of the agencies who would need to be informed in the event of abuse taking place.

Staff who regularly worked at the home were aware of risks associated with people's care and support. They were able to tell us about risks such as nutritional risks and those associated with moving and handling. We saw staff support people with equipment to help people with their mobility and found they were used safely. Risk assessments were seen to be in place and these were regularly reviewed. A fall diary was in place for people who had frequent falls as a means of identifying any patterns or trends to the falls as a means of trying to reduce the risk.

A newly appointed member of staff confirmed the provider had carried out a Disclosure and Barring Service (DBS) prior to them starting work at the home. The DBS is a national agency that keeps records of criminal convictions and therefore help the provider with safe recruitment.

Requires Improvement

Is the service effective?

Our findings

At our inspection on 23 March 2015 we found improvement was needed to ensure people were receiving the care and support they had consented to. We found the registered provider had not made the proper application of the Mental Capacity Act (MCA) 2005 as this had not been followed to show decisions were made in people's best interest. We identified this as a breach in legislation corresponding to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of the breach we rating this question as Requires Improvement.

We carried out a focused inspection on 19 January 2016 to assess whether the breach in regulation was met. We found improvements had been made. We found people were supported to consent to their care and support and to make their own decisions. In addition we found where people did not have the mental capacity to make specific decisions action had been taken to ensure these were made in their best interests.

Within our report following our focused inspection we acknowledged the improvements made. However we did not improve the rating to Good as we required a longer track record of consistent good practice in this area.

Staff we spoke with told us they had received training to enable them carry out their role effectively. One member of staff told us about their induction when new in post at the home had included training as well as working alongside experienced staff members. The same member of staff told us, "Moving and handling training really good." Staff told us they had received training. However, throughout the inspection we saw examples whereby staff were not putting into practice their learning. We saw examples of times when people's individual needs were consistently not met, infection control measure were not always undertaken to reduce the risk of cross infection and health and safety such as fire awareness was not maintained. Although staff confirmed they had received training and we were told by the deputy manager they had brought to the attention of staff shortfalls in practice we saw these to continue throughout the inspection. For example staff were seen not wearing protective gloves when carrying bags containing soiled items following people receiving personal care.

People told us they liked the food available at the home. One person told us, "Food is very good." Another person told us, "I think the food is excellent". One person told us food could at times be cold when served to them. People told us different dietary needs were catered for. We asked one person what they intended to have for lunch and they referred to the menu to tell us about the food available. The same person told us they would be able to select from the menu what they wanted to have for their lunch. Staff showed people who were sat in the dining room the choice of two meals available for them to select from.

Although we saw some good practice take place we also saw some occasions whereby people did not receive the support they needed in a timely way meaning they were unable to eat the food they had in front of them. On person was seen to have their meal for 25 minutes and was unable to cut up large items of food. This person did not receive assistance from staff during this time frame.

Following the findings of our focused inspection on 19 January 2016 we looked at whether the improvements made regarding the application of The Mental Capacity Act 2005 (MCA). This act 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. Records were held within care plans to showed were best interest decisions had been made and these involved in reaching the specific decisions.

Throughout our inspection and on the majority of occasions staff sought consent from people before they provided any care and support or before they took any action. For example staff asked people whether they wanted to go into the dining room for a meal.

People who lack mental capacity to consent to arrangements for the necessary care or treatment can only be deprived of their liberty when this is in their best interest and legally authorised under the MCA. The procedure for this in both care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted applications under the DoLS and where these had been authorised staff were aware of these and the restrictions. We spoke with staff and found they had an understanding of the MCA and how this affected they practice.

People told us they were supported to maintain their health. One person told us they were confident a GP would be contacted if needed. Relatives we spoke with told us they were made aware as appropriate regarding any concerns with their family member's health. A visiting healthcare professional told us they were called to see people at the home appropriately and believed staff meet people's medical needs. We saw evidence in people's care plans of a range of healthcare professionals having visited people or seen people as an outpatient. For example a podiatrist was asked to visit one person who had an issue needing attention.

Requires Improvement

Is the service caring?

Our findings

At the time of our last comprehensive inspection on 23 March 2015 we rated the caring question as Good. Following this inspection we have changed the rating to Requires Improvement.

People who lived at the home as well as relatives we spoke with described the care provided at the home and told us about the staff. All the comments we received were positive about the staff. One person told us, "Staff are very nice, caring and thoughtful to me." Another person told us, "Staff are fabulous, very helpful and very kind." A further person told us, "They [staff] look after me extremely well". While we were having a look around the home one person told us, "I like it here"

Comments from relatives included, "Staff seem very good" and "Marvellous". Relatives we spoke with described the care provided when their family member was at the end of their life and told us they could not fault the care provided. Relatives told us they were able to visit their family member at any time and would recommend the home. We asked staff whether they would recommend the home. One member of staff told us, "No comment." while others stated they would not. Another member of staff told us, "We do give care when we can but we are busy."

Staff we spoke with told us about how they ensured they up held people's privacy and dignity and were able to give us examples of how they did this. One member of staff told us, "We are hot on this" and, "It's a high priority." For example they told us they would close bedroom doors when personal care was carried out. Throughout the inspection we saw staff doing this. In addition we heard one member of staff speak with a person discreetly when they had asked to go to the bathroom.

However, there were saw times when dignified care was always not provided. We saw examples where people had their breakfast taken to them in their bedrooms. We saw one person with a piece of toast on their chest while they were asleep in bed. The care plan stated the person needed support with eating meals. We also saw a drink placed next to a person's continence aid. The deputy manager saw both of these examples and agreed there were not dignified.

We saw some armchairs had plastic covering around the cushion. This plastic was showing where fabric had shrunk. It was therefore evident people were sitting on furniture which needed to be protected against the risk of incontinence. The regional director noted our comments and the disrespect this could show to people as well as risks to people developing sore skin. They instructed the deputy manager to order new items immediately. We also brought to the attention of the managers an odour in the dining room which was not conducive to a pleasant environment in which to eat. We saw some pressure relieving cushions drying by a radiator. The deputy manager was unable to tell us to whom these belonged and told us they were thrown away after we brought it their attention.

We found areas of the home as well as equipment and furniture to be unclean or not suitable to provide quality care for people. For example two dining room chairs were dirty with breakfast cereal on them. Radiator covers were dirty and sticky.

Some people remained in their bedrooms and preferred to have their bedroom door open. We saw some staff knocked on bedroom doors before entering while others did not. Comments from people who lived at the home were mixed. One person told us, "Staff always knock the door before they come in and treat me with respect." Another person however told us, "Staff don't always knock before they walk in". A relative told us, "They [staff] always knock the door before they come in and treat my relative with respect."

One the first day of our inspection we found some glasses on a china bowl in the lounge. These were named we were told they had belonged to a person who had passed away some months previously. We returned to the home two days later and saw the same pair of glasses were on a table next to someone who was having their breakfast. Although it was not known how these were found where they were it showed a lack of respect for a former resident's possession. Other glasses were seen in the lounge. One pair belonged to a person who was in their bedroom. Their care plan showed they worn glasses.

We saw people's clean laundry hanging on handrails outside people's bedrooms. The deputy manager told us they were not supposed to be there. We saw a notice in the clinic room instructing night staff not to do this. We saw other examples during the inspection where by staff had not considered people's dignity and respect. These were brought to the attention of the deputy manager throughout our inspection who agreed staff were not always thinking and delivering poor practices. For example we saw one person who at times needed assist.

We brought to the attention of the deputy manager a sign on a communal shower room relating to the care and support of one person. They agreed this was not good practice as information about an individual was seen on display in a communal area. In we saw other examples of a lack to personal care such as personal toiletries left in a communal shower room.

This was a breach of Regulation 10, Dignity and respect of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

At the time of our last comprehensive inspection on 23 March 2015 we rated the responsive question as Good. People at the time of our previous inspection told us of the things they were able to do for fun living at the home and the activities available to them. Following this inspection we have changed the rating to Requires Improvement.

We looked at how long staff took to respond to a call bell on two occasions. Both of these were activated by the same person. Although a bell was sounding there was a lack of response from staff whereby staff on duty were seen not to respond. As a result the same person was left waiting for care and support on at least twice for 15 minutes on each occasion. We brought our observation to the attention of the deputy manager. We saw some people were without their call bell within reach. The deputy manager confirmed one person should have theirs and found it under the person's bed. After we spoke with the deputy manage about call bells a relative told us it was the first time their family member had theirs available to them for six months. The lack of call bells or the lack of suitable response to call bells sounding potentially placed people at risk if they needed urgent assistance to maintain their welfare.

People who spoke with gave a mix of comments regarding the availability of activities and hobbies and interests for people to take part in. Some people told us they preferred not to participate in things such as days out and elected to stay in their own rooms. One person told us, "Our last activities co-ordinator left and we used to do a lot. They were good at getting us moving, gardening, art classes. I miss that." The same person added, "There is not much talking going on just shouting." Another person told us, "In the past we used to make things, they encouraged us to do things." We asked one person what there was to do for fun at the home who told us, "Nothing" and, "Can get bored." The same person told us in the past it was, "Lively" at the home and they had a lot of activities before.

Information within the provider's brochure stated people living at the home 'are encouraged to partake in the many daily activities that are offered throughout the home and beyond. Typical activities include baking and craft sessions, music therapy and day trips.' Other information within the pack stated, 'Activities make up the most important part of all our days . .' and continued, 'All group and individual activity is designed to not only mentally and physically stimulate the people we care for but to enhance their life skills and feelings of purpose and self-worth.'

We saw on display information about planned activities over the week. On both days of our inspection this information was on display on both a visual board as well as a printed timetable in a frame. Other information was displayed elsewhere in the home. Events advertised over the days of our inspection included light exercises, word games, arts and crafts, walkers club around the garden, sing a long, bingo and throwing hoops did not happen.

The activities coordinator was working as a care assistant due to staff shortages. They told us they had worked as a care assistant for the previous three weeks and were on the rota to continue in that role for a further three weeks. We spoke with another member of staff about the information displayed regarding

things for people to do for fun. They told us the schedule "Doesn't go to plan" and confirmed the events listed to take place did not happen. Throughout the inspection we did not see examples of staff spending time to support the emotional and social needs of people. We saw examples when people who lived with dementia sought staff attention to spend time with them to provide reassurance. This level of support was not available to people due to other demands placed onto staff.

We saw some skittles placed out in the lounge. One person commented about these telling us they were put out and then just left as nobody had done anything with them.

We spent time observing practice and saw little staff interaction with people who needed a high level of support. There was minimal staff presence in lounge areas throughout the inspection.
This resulted in a person either calling out or banging their drink container on a table seeking staff attention due to their anxiety. This person indicated distress when they were on their own and was seen to be more relaxed when they had staff with them providing the reassurance they sought. We saw when staff were able to afford time with people this was primarily in order to provide personal care.

We observed a lunch time and found people were not always getting the level of support they needed and a lack of good practice and person centred care take place. For example people were seen picking food items up by their fingers as they were unable to cut items such as a Yorkshire pudding or roast potatoes this resulted in one person dropping food down them. Staff did not intervene or offer people assistance when they were seen either not eating or not managing. One person was seen trying to eat soup with their hands as they could not identify which utensil to use. We saw the same person try using a knife and fork to eat the soup until after 15 minutes a member of staff gave them a spoon. We saw one person's sweet left to go cold when they were taken to the bathroom. People who had needed to use their hands were not offered any means of wiping them afterwards.

This was a breach of Regulation 9, Person - Centred Care of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were confident they could raise any concerns or complaints they had about the service provided. We looked at a file holding complaints and complements. One person told us, "I have not had to raise any concerns or complaints but I do know who I would need to talk to if I did have any." Another two people made similar comments as did two relatives. The provider's complaints procedure was on display in the reception hall for people to refer to.

We saw a file containing compliments made about the service provided. The same folder contained an e-mail following a complaint dated March 2017. There were no details available regarding the complaint. We asked the deputy manager who was not aware of the issues raised.

Inadequate

Is the service well-led?

Our findings

At the time of our last comprehensive inspection on 23 March 2015 we rated the well led question as Good. The rating of Good was on display near the front door as well as on the provider's web site. Since our last comprehensive inspection in March 2015 there have been changes within the management team at the home. The former registered manager left their employment with the provider. A new registered manager was registered with the Care Quality Commission in January 2016. Following this inspection we have rated this question as Inadequate.

The registered manager was on short term leave at the time of this inspection. Staff we spoke with told us they did not see this person very often and referred more to the deputy manager based at High Habberley who was present throughout most of our inspection. Staff spoke highly of the deputy manager. We also spoke with the regional director who was also present for part of the inspection process.

Systems were in place to monitor and assess the quality of the service provided. We found these systems were not effective to ensure good governance and oversight of the service provided for people living at the home.

We saw occasions during the inspection when people's needs were not able to be responded to. These included delays in answering call bells and lack of support for people while having meals. Staff told us they were unable to meet needs in a timely way due to the number of staff available. Within the Provider's Information Return (PIR) we were told, 'Staffing levels are arrived at by using the DICE tool.' The DICE tool was a management tool used by the registered manager to determine the dependency levels of people who lived at the home Staff felt the tool did not take into account the layout of the home and the individual needs of people living at the home. One member of staff told us they were not allowed to talk with the Care Quality Commission about staffing levels.

Staff told us they had complained about staffing levels but were referred to the DICE tool and its allocation of staffing hours required to meet the needs of people living at the home.

The deputy manager told us they would when possible have a walk around the home to observe practices. They told us they had previously brought to the attention of staff areas where improvement was needed. However, we saw examples of poor practice take place as well as practice which could pose a risk of harm and or injury to people.

Our inspection commenced on the hottest June day for 40 years and during a continual warm period of weather. Despite this we found some radiators to be on. One radiator was particularly hot. A member of staff commented, "We keep telling them to shut them down. It is boiling in here." This was brought to the attention of the deputy manager. We were informed these radiators were turned off on the first day of our inspection. However, as a result of this there was no hot water to two bedrooms.

We found areas around the home in need of repair and attention. We brought to the attention of the deputy

manager some radiator covers which were coming away from the wall. These remained the same when we returned on the second day of our inspection. We saw a maintenance book was in place for staff to record repairs needed. There was no evidence to demonstrate any oversight of the requests made to ensure they were carried out and therefore to ensure people were living in a safe environment. The records included radiator covers. One entry in the book dated 31 March 2017 showed an urgent request to repair a radiator coming off the wall. There was no evidence this requested was attended to. We saw the radiator cover in this room was not fixed to the wall and therefore at risk of falling over. We saw a request to replace some 'knobs' on an item of furniture. This was not done and we saw no evidence of how this work to improve the look of the home was to be carried out to ensure people had a pleasant and safe place to live.

We saw risks to people's safety in the event of an emergency. We saw a door to an empty bedroom propped open by a hoist. Leading from the bedroom was an external fire escape. The deputy manager told us the bedroom door should be kept closed and having the door propped open was a, "Fire hazard". The floor leading to the fire escape was not clear with obstructions such as a pressure relieving mattress and pressure mats. These would in the event of an emergency have posed a risk to the ability of people to leave the building safely. The ramp leading from the fire escape outside had brambles growing over it which could have hampered people's ability to exit the building in an emergency. Other hazards were seen within the open bedroom including a loose light fitting and a bed which was partly dismantled. We brought our findings to the attention of the deputy manager and the regional director. When we returned to the home on 23 June 2017 we saw the floor was clear of obstacles.

We viewed the fire risk assessment and saw reference to potential changes to the bedroom containing the external fire escape. The assessment made no reference to the current arrangements such as having the door locked and a key available in a break glass. The risk assessment highlighted a need for staff training. The deputy manager assured us the registered manager had made this a priority and was been dealt with. The deputy manager was unable to access training records during the inspection. These were sent to us to view. These showed the majority of staff had undertaken fire training. However less than half the staff were recorded as having undertaken evacuation training and nobody had undertaken fire drill training.

We looked at the fire safety records and saw regular testing of the fire alarm was taking place. The record stated the test must be carried out using a different call point on a rotational basis around the building. We saw one fire bell point had not been tested since September 2016 and the bungalows which were not in use at the time of the inspection were not forming part of the checks. This meant the whole system was not been tested for any faults. We noted a sign showing the designated fire assembly point was lying flat on the ground.

The regional director told us they had spoken to other people within the organisation and awaited their visit and guidance. We brought our concerns to the attention of Hereford and Worcester Fire and Rescue Service.

Systems in place to ensure people were not placed at risk of suitable or unsafe equipment were not suitably in place. We saw a hoist with a sticker showing it had failed a service at the end of January 2017. One person as well as staff confirmed this piece of equipment was in use. We asked to view documents about equipment used to move or lift people safely. We were unable to find additional document which showed some of the required work had taken place. Although assessed as safe to use repairs were needed on other pieces of equipment. This work had not taken place and was not scheduled to take place. There was no evidence of a scheduled six monthly safety check on these pieces of equipment.

The deputy manager was aware of the requirement to inform the Care Quality Commission of certain events and incidents within the home. We saw reference to an incident which had occurred in October 2016. We

were not informed about this incident. Following our inspection we have received a notification retrospectively.

This was a breach of Regulation 17, Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they found the deputy manager and the nurses to be supportive and we were told they would assist in the provision of care for people when needed. The deputy manager told us she was supported by the registered manager.

The deputy manager confirmed they attended a daily heads of department at another home registered with the same provider on the same site. These meetings involved the registered manager when on duty as well as other key members of staff and were used to share important information.

Following the inspection we were sent a copy of a Quality First assessment carried out in February 2017on behalf of the provider. We saw this highlighted some concerns relating to the décor and the environment looking 'tired'. The regional director confirmed a programme of redecoration was to take place. The audit highlighted some other areas were improvement was needed. We saw these areas were ticked to indicate the necessary action had taken place.

Audits were completed by management at the home in relation to medicines. We saw these audits highlighted any gaps in records and areas where improvement was needed. We were informed of a recent audit carried out by the pharmacy and informed they were happy with the practices checked.

We were informed of out of hour's checks and saw records following visits made by the registered manager to monitor the quality of care and support taking place for people at these times.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People did not always receive care and support in a timely way to meet their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People did not always received care and support in a dignified and respectful way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not have effective arrangements in place to monitor the safety and quality of the service provided when improvement was needed.