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Higham House Nursing Home

Inspection report

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Tel: 01933314253

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

Summary of findings

Overall summary

Higham House is located in the village of Rushden in Northamptonshire and provides people with accommodation, personal care and nursing care. They are registered for up to 30 older people who may also be living with conditions such as dementia. On the day of our inspection there were 27 people living at the service.

We previously carried out an unannounced focused inspection of this service on 11 November 2016 and identified one breach of legal requirements. We found that areas of the service were not always clean and free from the risks associated with infection control. There were not effective cleaning schedules or logs in place to ensure cleaning was carried out as required.

We asked the provider to take action in response to our concerns around these areas by 15 December 2016 and issued the provider with a warning notice for this breach. On 6 January 2017, we carried out a focused inspection to see whether the provider had followed their improvement plan and confirmed that they were now meeting legal requirements. During this inspection we returned to undertake a comprehensive inspection of the service and to ensure that standards had still been maintained in respect of infection control and cleanliness.

This inspection took place on 1 March 2017and was unannounced.

We found that accidents and incidents had not always been reviewed appropriately to determine whether they should be raised as a potential safeguarding. This meant that not all incidents had been referred to the local authority for further investigation and that appropriate action was not always taken to keep people safe from abuse or neglect. Potential service user on service user safeguarding incidents had not always been reported to the relevant external agencies.

Risk assessments were not always reflective of people's current needs and did not always contain sufficient information to guide staff. The risk assessment process was however due to be evaluated as part of a review of all care plans.

There was not always sufficient staff on duty, with the correct skill mix, to support people with their needs. Staff were only able to meet people's basic care needs but did not have the time to provide them with any meaningful support during peak times because of their deployment within the service.

Staff supervisions were not completed on a regular basis which meant that staff did not always have a record of formal discussions which took place. All staff said they felt well supported by the registered manager, who accepted that they needed to review the supervision system in place to bring this in line with the provider policy.

Although there were systems in place in respect of the Mental Capacity Act 2005 (MCA) these were not

always used appropriately to ensure that decision specific assessments were completed for people.

Care plans did not always provide staff with sufficient guidance to meet people's specific needs and wishes and were often not user-friendly. We found that some aspects of the care plans had not consistently been reviewed and there was not always evidence to show that people or their families had been involved in reviewing them. As a result they were not always reflective of people's current needs and requirements.

Quality monitoring systems and processes had not always been used as effectively as they could be to ensure that action was taken to make improvements when required. Satisfaction surveys had been completed but there had been no attempt to analyse or have oversight of the outcome of these in order to drive future improvement. Audits were carried out however; they failed to highlight key areas of the service in which improvements were required. There was a lack of management and oversight systems in place, which meant the registered manager and provider, were unable to monitor, assess and drive improvements at the service.

People were not able to comment on whether they felt safe but their demeanour was generally relaxed in the presence of staff. Staff had received training although we received mixed responses in their feedback as to the action they would take in the event of a possible safeguarding incident.

Robust recruitment checks were completed to establish that staff were safe to work with people before they commenced employment. Systems and processes in place ensured that the administration, storage, disposal and handling of medicines were suitable for the people who lived at the service.

During this inspection, we found that improvements had been made to the systems in place within the service, to ensure that appropriate standards of cleanliness and hygiene had been maintained. Staff had reviewed their practice in respect of cleaning, and had worked hard to ensure this was now more thorough.

Staff were supported through a system of induction and on-going training, based on the needs of the people who lived at the service. They also benefitted from additional informal support with free access to the registered manager which enabled them to discuss any concerns and training and development needs.

People were able to make choices about the food and drink they had, and staff gave support when required to enable people to access a balanced diet. There was access to drinks and snacks throughout the day. We found that people were supported to access a variety of health professional when required, including opticians and doctors, to make sure they received appropriate healthcare to meet their needs.

Staff members treated people with kindness and compassion. They worked to develop positive relationships with the people they cared for and treated them with dignity and respect. Visitors were welcomed to the service and staff members spent time getting to know them and working alongside them to ensure people's needs were met.

There was a positive culture at the service. Staff were motivated to perform their roles and felt well supported by the registered manager. They were able to talk to the registered manager about any concerns they had and seek guidance and support.

We identified that the provider was not meeting regulatory requirements and was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of 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 always safe.

People felt safe although we found that not all staff were fully aware of their responsibilities in terms of safeguarding and potential abuse. This was highlighted by the lack of appropriate action taken with recent accident and incident reports.

Accidents and incidents had not always been reviewed appropriately to determine whether they should be raised as a potential safeguarding.

Risk assessments were not suitable or robust enough to ensure that staff were aware of risks to people at the service. There was a lack of control measures in place to reduce the levels of risk posed to people.

There were not always sufficient numbers of staff on duty, with the correct skill mix, to support people with their needs. The deployment of staff needed review to enhance the quality of care that people received.

Recruitment practices were robust to ensure that all staff members were suitable to work at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People's consent to their care, treatment and support arrangements was not always sought by the service. For people who lacked the mental capacity to do this, the principles of the Mental Capacity Act 2005 had not clearly been adhered to.

Staff members did not receive regular supervision, to provide guidance and support in their roles. This was however in the process of being addressed. Staff members did receive regular training, to equip them with the skills they needed, although we found that further strengthening of monitoring of staff competencies in some areas was required.

Food and drink was provided, to ensure people's dietary needs

were met. People had a choice of what they ate and their specific wishes and needs were catered for.

People were supported to maintain appointments with healthcare professionals within the service and the local community.

Is the service caring?

Good

The service was caring.

People were supported with care and kindness. Staff worked to develop positive relationships with them.

People were treated with dignity and respect by members of staff who worked to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive person-centred care. Care was task-based and plans did not provide staff with personalised, specific information that they required to meet people's needs and wishes.

People were not always provided with sufficient activities and stimulation by the service.

There were systems in place to receive and act on any complaints or feedback raised

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There had been an adverse impact to the overall managerial oversight of the service caused by the recent absence of the registered manager when they undertook a series of night shifts.

Records were not always well maintained or up to date in respect of people.

Systems to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment were not always effective as they had failed to highlight some areas of the service which required attention.

Staff members were generally positive about working at the

service and working with the people they provided care for. They felt they were well supported by the registered manager. There was an open and transparent culture within the service.

Higham House Nursing 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 March 2017 and was unannounced.

The inspection was carried out by two inspectors.

Prior to the inspection we had received some information of concern regarding the way in which people were cared for, staffing levels and the general lack of oversight of the service in respect of management. We checked the information we held about the service and the provider, such as notifications. A notification is information about important events which the provider is required to send us by law. In addition, we asked for feedback from the local authorities and clinical commissioning groups, who both have a quality monitoring and commissioning role with the service.

During the inspection we used different methods to help us understand the experiences of people using the service, because some people had complex needs which meant they were not able to talk to us about their experiences. 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 observed how staff interacted with people who used the service and also observed breakfast in the main dining area and in the communal areas.

We spoke with three people who used the service and observed a total of 17 others who could not express themselves verbally because of their complex needs. We also spoke with two senior carers and two care staff, one nurse and the registered manager.

We reviewed care records for four people, as well as other records relating to the running of the service such as: staff rotas, medication records, and accident and incident records; to corroborate our findings, and to check the delivery of service in these areas. Records relating to the management of the service were also seen, such as audit and quality assurance checks, to determine the level of service that was provided.

Requires Improvement

Is the service safe?

Our findings

When we reviewed accident and incident records we found that not all potential concerns had been reported to the local authority or the Care Quality Commission (CQC), once staff had completed an incident report. Staff told us that they would complete an incident form if they noted a bruise or wound when delivering personal care or if they had witnessed a service user altercation and would inform the registered manager or nurse in charge. However, when we checked accident and incident records, we found that although these incidents had been documented in both the daily progress notes and on the incident form, no identifiable action had been taken to determine if the incident should be referred for further investigation. This meant that reportable incidents had not always been accounted for in the appropriate manner.

We also found that accident and incident records often lacked detail and did not always consider appropriate interventions for managing behaviour or the risk of falls, when compared against guidance in people's care plans. As such, from the information provided on the records, we found that it was not always possible for the provider to investigate and take action to ensure that people were safe from avoidable harm or abuse. In addition to this, there was no evidence to show that potential safeguarding incidents had been analysed or used to identify trends which may indicate that abuse had taken place. This meant that people were not always protected from avoidable harm or abuse and that there were ineffective systems in place to protect people from abuse.

We discussed this issue with the registered manager who acknowledged that the systems in place had not enabled a robust oversight of the accidents and incidents that had taken place. They discussed with us how they would make improvements to the systems in place to ensure that people were kept safe.

Although staff members had received recent training in safeguarding, some staff were more aware of abuse and the different forms that it could take than others. We received mixed comments about the action that staff would take; some staff did not have a good awareness of the appropriate action to take. One staff member told us, when asked about safeguarding, "Check the wheelchair, and put the seatbelt on and brakes. People are walking; just make sure they have their Zimmer and follow them." When asked further they were able to confirm they would raise any concerns with a nurse but this took some time to establish. This lack of awareness was highlighted by the incidents we identified that had not been considered as potential safeguarding matters. Our records did however show that we had previously been notified of other safeguarding concerns.

Systems and processes were not operated effectively to ensure that people were protected from potential abuse. This was a breach of regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Individual risk assessments were not always followed appropriately by staff in order to keep people safe and free from harm. Although they provided staff with the basic guidance they required to support people, we found that this information was not followed consistently in practice. Staff members told us that they used

the risk assessments to guide them in the delivery of care; however our observations found that this was not always the case. For example, we observed staff supporting someone to transfer. On two occasions, they used different techniques, first a hoist transfer and then they supported the same person without the use of equipment. We asked the registered manager about this and were informed that the person had variable mobility, but this was not clear from the guidance in place. Therefore risk assessments were not always used effectively by staff to care for people in accordance with their needs.

We found there was no defined method of formulating the assessed score of low, medium or high and no identifiable method of establishing the required action as a result of this. Therefore if staff needed to seek additional support for people, the risk assessment process did not always provide them with robust risk management strategies.

For example, we found that one person had a nutritional risk assessment in place, which gave a risk rating of 'high risk'. There was no evidence in the risk assessment to demonstrate how this rating had been determined, or the resulting action that should be taken. For example whether a referral to a dietician or GP or was required for additional intervention. Neither was there any information as to the frequency with which the risk assessment should be reviewed on the basis of the high risk rating.

For another person, who had a risk assessment in respect of their mobility, at the time of our inspection we were informed that they were on bed rest due to deterioration in their condition. According to the action required when a person was deemed to be high risk, this should have meant that the person was reviewed weekly to ensure that all mitigating actions had been considered to reduce the risk of falls. Records confirmed that this had not been done, with monitoring taking place on a monthly basis. The person had not come to any harm because of this as they had been cared for in bed; however it meant that the guidance contained within the risk assessment was inconsistent with the provision of care.

We spoke to the registered manager and nurse in charge of the shift about the issues we had found in respect of risk management. They agreed that the risk assessments in people's care plans were inconsistent with their assessed needs and said that they would review them with immediate effect, to ensure they were accurate and provided staff with the information they needed. They told us they wanted to ensure they were robust so as to keep people safe from harm.

Risk assessments did not reveal a full understanding of the risk assessment process, or of the necessity to provide robust control measures to mitigate risk. These were breaches of Regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, we observed that there was not always sufficient staff on duty to meet the needs of people. We found that their deployment within the service could have been improved. Members of staff told us that one of them should be in the lounge areas at all times; we noted their absence from the communal areas on many occasions during our inspection. We saw that the meal time experience for people would have benefitted from more prominent staff. For example, one person was left to eat their dessert during lunch time. They were left without support from staff, and during that time the food started to fall from the bowl. Had staff been better deployed and more in number, the mealtime experience could have been made more pleasurable.

For another person, who required frequent reassurance and wanted to have someone to hold their hand, staff frequently acknowledged the person as they walked past the lounge but were busy with their duties and unable to sit and provide them with the comfort they needed. There were occasions where there was not a member of staff present in the communal areas, and during one of these times, one person stood up

and then fell towards another person sitting the chair beside them resulting in them falling to the floor. It took a number of minutes for staff to come to support them with the cook being asked to go and find the nurse by the registered manager to ensure the person was checked over. We also observed occasions whereby during periods when the staff had left the communal areas, verbal exchanges between people quickly escalated and could have led to distress if we had not intervened.

Staff told us that although they had time to provide people with the basics; that they could not always spend meaningful time with people. This was born out in their approach to people, which although caring, was often task focused. One staff member told us, "I don't think there is always enough of us on duty. I don't know how there is five of us today. There have sometimes only been three and one time only two when someone called in sick and they didn't get any cover." However another staff member said, "There is enough staff on duty to help everyone."

The registered manager told us that the service did not have a formal dependency monitoring tool in place to assess the numbers of staff required on each shift to ensure people's needs were being met. They stated that staffing levels were based on the needs of the people living there. However, there was nothing within people's care records to determine individual dependency levels or match these against the required numbers of staff.

Records confirmed that one nurse and five care staff were on duty in the morning and afternoon, along with one nurse and two care staff at night. In addition to this the service had support from the registered manager and ancillary staff. Records confirmed that agency staff were used, but we saw that these were consistent to enable continuity of care.

There was not sufficient numbers of sufficiently skilled staff on duty to provide people with care which met their assessed needs. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout our inspection we observed that staffing levels matched those on the staffing rota. The registered manager confirmed that if there were any changes within people's needs the staffing numbers would be adjusted accordingly to keep people safe. We discussed our concerns with the registered manager who took our feedback on board. They agreed they would monitor this aspect to ensure that people received the best possible experience during peak times of the day with better staff deployment.

Staff were recruited following a robust procedure and told us that they had to wait until their references and DBS (Disclosure and Barring Service) checks were complete before they could start work. Records confirmed this to be the case.

People's medication was administered safely. One person said that they always received their medication on time because staff supported them with it. We observed the nurse return to the lounge to provide medicine to one person who she had identified as being 'too sleepy' when she first approached them. She crouched down to their level and explained each medicine to them; for example, "This is the chewy one [Name of person.]" Medicines were stored securely in a locked cabinet and the temperature of the office checked on a frequent basis. Records evidenced that medicines were administered by staff who had received appropriate training and had their competency assessed to ensure their practice was safe. Regular audits were completed which helped to ensure the systems and processes used were robust.

People told us their bedrooms were cleaned to a good standard and were clean and smelt fresh. Our observations confirmed this, and we found that all through the service, improvements had been made to

the cleaning systems since our last inspection. Communal toilets and bathrooms had been cleaned to a good standard. We found there was on-going cleaning in operation, and that a more robust audit system had been implemented to ensure that areas of the home had been cleaned. This was based upon the areas identified as issues in our previous inspections.

The registered manager told us that as a result of our last inspection, staff were now more vigilant to infection control and standards of cleanliness throughout the whole service. We observed there was a sufficient amount of housekeeping staff on duty that were undertaking cleaning and wore protective equipment to do so. Staff had access to a good supply of protective equipment for the tasks they were carrying out, for example, disposable gloves and aprons when assisting with personal care. We found that there were good supplies of cleaning equipment, with mops and cloths for use within different areas.

The registered manager confirmed that a schedule for required maintenance work across the service was in place. This took into account repainting of communal areas and attending to any required maintenance issues. It was hoped that this would also enable the service to be more easily cleaned, but also to ensure it was more dementia friendly for the people who lived in the service.

Requires Improvement

Is the service effective?

Our findings

People's consent to their care and support was not consistently sought by the service. We found that care files lacked signed consent forms to demonstrate that people, or another responsible person such as a family member, had given their consent to the content of those files or for their photograph to be taken as part of the records. We saw that each individual care plan had an area for people or their relative to sign to say that they agreed to the content of that plan, however; only one of the care plans we looked at had been signed and this was over 3 years ago. People were not able to tell us how people's consent to the content of their care plans had been sought or recorded. This meant that people received care which was not provided with their consent, or the consent of another relevant person.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The principles of the MCA were not always being followed. Staff members told us that there were MCA assessments in place which found people lacked capacity, when they felt the person was able to make decisions for themselves. One staff member said, "I don't know why they have one [MCA assessment], they can tell you what they want." Records showed that MCA assessments were not carried out in a robust manner. We saw that these assessments were not always decision-specific; rather they gave an overall finding that the person lacked capacity. This is contradictory to the guidance in the MCA and may have prevented people from being able to make decisions for themselves. The assessments also failed to provide evidence of how the person had been found to lack capacity, or what staff did to help provide people with information about the decision in question.

There was also a lack of evidence that a best-interests' approach was taken when decisions were made on people's behalf. When MCA assessments were carried out, the form used at the service contained a best interests' checklist. These were usually completed, but did not show any evidence of how the answers had been arrived at. There were 'yes' or 'no' answers selected within the checklist, but there was no explanation as to how these answers had been decided. There was also nothing to show that those people involved in a person's care, such as family members or social workers, had been consulted in the assessment or best interests' process. The only person involved in making assessments and decisions on people's behalf was the member of staff completing the form. This meant that the principles of the MCA were not being followed and that there was a risk that decisions made on people's behalf were not in accordance with their best

interests'.

We also found four Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place that had been signed by a doctor. These had been ticked to say they had been discussed with the person, but there was no evidence of this as it had only been signed by the completing doctor and not the person. We could not be clear if the person was aware of, or understood the reason for, the decision being made in line with best interest procedures.

Care and treatment was not always provided or planned with people's consent. Where people were unable to consent or make decisions about their care, the principles of the Mental Capacity Act 2005 had not been adhered to. This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members told us that they sought people's consent on a regular basis. They explained that before they provided any specific care or support they would check with the person to make sure they were happy with what they were going to do. During the inspection we observed that staff members explained what they planned to do and made sure people were comfortable with that. People's choices were respected and staff ensured they provided people with care in line with their wishes.

There were systems in place to make sure that referrals under DoLS were made appropriately. The registered manager told us that they had completed DoLS referrals for those people who were at risk of having their liberty restricted, and records confirmed this. We saw evidence of completed DoLS referrals, as well as correspondence between the service and the local authority.

Staff members did not always receive regular supervision sessions from the registered manager. One staff member told us, "I have not had a supervision at all." Another staff member said, "Sometimes we have a piece of paper to fill out before we meet with the registered manager." They told us that although they received the opportunity to talk with the registered manager, who was accessible and approachable, that in respect of formal supervision, this had decreased in frequency. Staff appreciated the opportunity to have formal supervisions as it enabled them to discuss their performance, raise concerns about the care that people received or any learning and development needs they may have. Staff members did tell us that they felt they could approach the manager if they needed to; however there were no records to show that concerns were raised by staff, or acted upon by the registered manager.

We spoke with the registered manager, who confirmed that supervisions for staff members had not been conducted on a regular basis since they had undertaken a series of night shifts to cover staff vacancies. They told us that they had regular staff meetings; however there were no systems in place to ensure that staff received one-to-one sessions on a regular basis. This meant that staff did not always have allocated time to discuss any concerns they may have. The manager had taken action to begin to address this and we discussed training senior staff members to conduct supervisions at the service. For example, having nursing staff trained to provide supervisions to care staff.

Staff members were not consistently provided with sufficient supervision to ensure they had the knowledge, skills and support to perform their roles. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff members at the service benefitted from receiving a formal induction when they started. One staff member said, "I did some shadowing when I first came here but was soon working on shift because of my past experience in care." The registered manager told us that there was a formal induction process in place,

and that when new staff members started they were shown around the service. They started by shadowing more experienced staff before being allowed to work independently. Staff members confirmed that this took place. There were records to show that staff members received an induction at the service, and that this was based upon the Care Certificate which covered all essential standards of care. The registered manager also told us of their plans to have all existing staff complete the Care Certificate as well to give them a good basis upon which to provide care to people.

Members of staff did tell us that they received training from the service; to help equip them with the skills they needed to perform their roles. One staff member said, "I have done my safeguarding training, manual handling and health and safety. I have also done end of life care and dementia. I have finished NVQ level two and might do my level three." Another staff member told us, "I've done my manual handling, health and safety and dementia courses." The registered manager maintained a training matrix, which showed when staff completed training courses and when they needed to be booked in for additional or refresher courses. We also saw certificates for completed training courses, including individual modules of the Care Certificate. This showed that staff members received training in key areas, such as safeguarding, moving and handling and medication administration.

We did however have some concerns about the efficacy of the training received by staff, particularly because of some of the manual handling techniques we observed being completed or the way in which accidents and incidents had not been realised as being potential safeguarding concerns. We discussed this with the registered manager who acknowledged our concerns and stated they would try and source additional training in these areas; whereby competency based consideration could be given to staff's knowledge.

People were happy with the food and drink they were given at the service. They told us that they enjoyed the food and were given a choice of what they wanted to eat and drink on a daily basis. One person told us, "Yes, I like all the food." Staff members told us that people were supported to choose what they wanted for each meal, as well as regular drinks throughout the day. During the inspection we saw that people were given a choice of what to eat and drink, as well as where they had their meals and drinks, including the option to eat in their rooms if they wanted to. Where necessary, staff provided people with support to eat and drink and did so in a calm and patient manner.

Staff members were able to tell us about any dietary needs and preferences that people had, including specific cultural needs that people may have. The registered manager told us that the kitchen was able to prepare alternative meals to suit people's individual choices, as well as freshly made drinks and snacks, so that people had something to eat throughout the day. We saw that people's dietary needs were recorded and there were systems in place to record and monitor people's dietary intake, if this was required.

People were supported to see healthcare professionals, such as GP's, district nurses and dieticians, by the service. Staff members told us that they regularly arranged for people to see these professionals, to ensure their health needs were being met. The registered manager also told us that, if required, staff members could support people to attend appointments in the community, including hospital appointments, if necessary. Following on from a recent local authority visit, the registered manager was in the process of implementing a robust process to record, plan and monitor healthcare appointments and was further ensuring that some form of process was in place to ease the transition when people were admitted to hospital in an emergency situation.

Good

Is the service caring?

Our findings

People told us that they got on well with the staff and that they treated them well. One person when asked if they liked the service and the staff supporting them, said, "It's fine." Another person told us, "I'm well here, thank you." Another person said in respect of staff, "They are all fine." Staff members treated people with kindness and compassion.

There were positive relationships between people and the staff members caring for them. Staff told us that it was important to them that people were well cared for at the service. One staff member said they wanted to, "Look after and care for people." During our inspection we saw that staff were positive in their interactions with people. They spoke to people using their preferred names and displayed a calm and empathetic approach. People were not rushed to perform tasks or answer questions and staff used simple gestures and reassuring touch, such as a pat on the arm, to help keep people calm and relaxed. Staff displayed this caring approach whilst meeting people's care needs.

People's privacy and dignity were maintained by staff members. People told us that staff worked hard to make sure they were treated with dignity and took steps to help preserve their dignity. They told us that staff members supported them to be as independent as possible, but they knew they were there to help them whenever they needed it. Staff members told us that they received training in dignity and respect and worked hard to ensure that people were treated in the way they would like their own family members to be treated. During the inspection we saw that staff were respectful towards people and were sensitive to their needs and wishes.

People were encouraged to maintain contact with their family members and the service welcomed visitors at all times. One person told us, "I get lots of people come and see me." Staff members confirmed that visitors could come to the service at any time to see their loved ones. During our inspection, we saw a number of different relatives come and go. Staff made them feel welcome at the service and were able to share any developments regarding the service or their family members care with them, as appropriate.

Requires Improvement

Is the service responsive?

Our findings

People's care was not always delivered in a person-centred manner or reflective of their specific needs. People had care plans in place but were unable to comment on the content of them or to say whether they felt their care met their needs, due to their complex needs. When we asked staff if they thought the care plans offered them information to guide them in the provision of care, one staff member said, "We read the care plans to get to know people or the nurse tells us at handover." Another staff member told us, "We can check people's files and look at their plan."

We reviewed people's care plans and found they did not always guide staff as to the most up to date care that people required. For example, one person had deteriorated in their condition and was now cared for in bed. We found that this information had not been incorporated in to their care plan, where it still appeared as though they could mobilise independently. There was no evidence to suggest that this omission had impacted upon the care the person received. However, this meant that the written assessment of the person's mobility was not reflective of their current needs.

For another person who presented with behaviour which challenged, there were no guidelines in place. For example, it was apparent during the inspection that this person became easily agitated but there was no reference to the specific details that caused this in the care records. This meant that staff did not have specific and individualised guidance on how to address the increasing level of challenge for this person.

We also found that, whilst care plans recorded people's needs, they did not always demonstrate that people's individual wishes and interests had been taken into account. They were often task focused, lacking in person centred information. For example, for one person, their communication care plan stated, "Communicates in muffled words- repetitive." It offered no advice or guidance to staff as to whether objects of reference or pictures could be used to enhance communication for this person. In another care plan in respect of someone's cognitive ability, it simply stated, "Has poor cognition." There was nothing to clarify exactly what this meant in respect of the impact of this upon the person's ability to comprehend information.

Care plans showed that there were regular reviews of people's care plans, however they did not show that people had been consulted, or that their family members had been invited to contribute to the review process. This meant that care plans were not always reflective of people's current needs and wishes and therefore did not provide staff with the information they needed to ensure that people's preferences were being met by the service. There was however no evidence to suggest that any harm had been caused to people by this lack of information.

The content of the care plans did not provide up-to-date information which was reflective of people's needs. For example, we saw that one person had a care plan in place which stated the person could be non-compliant with their medication at times. It failed to provide details of likely settings or indicators when this may occur, or details of action which staff should take if they did refuse their medication. We spoke with the nurse in charge and were informed that this had been discussed but did not take place. This meant that staff

members were not provided with the specific information they needed to provide person-centred care. People's care plans did not contain person-centred information and failed to provide staff with specific guidance about the support that they should be giving people. This meant that staff provided people with care that was not in always in accordance with their needs or interests.

Staff members told us that care plans were reviewed regularly, to update and evaluate them and make any changes that were necessary. We found that this was inconsistent. Some care plans had been reviewed, but others had not been.

We observed lots of conversations between staff about who 'had been done' or who had received a drink. This identified that organisation of people's care was poorly coordinated and staff members were not considering people's care needs in the most person centred way possible.

Care and treatment of people living at the service did not always reflect their preferences or meet their specific needs. Care plans were not person-centred. This was a breach of regulation 9 (1) (a) (b) (c) (3) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the activities coordinator at the service. They told us that they were also a member of the care team and we found that they were knowledgeable about people and what activities they liked. They explained that they provided a range of different activities such as arts and crafts, and told us, "We do trial and error and see how everyone gets on. We plan more now after you said to the last time you come for the inspection."

During our inspection, we saw no activities take place; people were left in communal areas of the service with little stimulation, apart from when staff passed them by. Staffing levels did not allow care staff the time to supplement the activities provided by the lead; therefore people were not able to receive engagement and stimulation. We were unable to find an activities schedule on display at the service, which meant people were not aware of what was going on and when it was going to happen. There were some activities provided at the service, however; there was no evidence that people had a range of activities to take part in, to suit their individual preferences. This meant that the service were not supporting people to follow their own interests and were not tailoring the activities which were provided to meet people's individual needs.

Records did not always demonstrate that people had taken part in activities; therefore we were unable to determine people's level of engagement in activities prior to our visit. This meant that people did not have information available to them about what activities they could take part in at the service, in addition; they had not been involved in planning the activities which did take place.

People and their family members were aware of the complaints procedures at the service. They were able to raise any concerns they had both informally and formally if necessary, although none of the people we spoke with had felt the need to do this. Staff members told us that they encouraged people to raise any concerns they may have so that problems could be put right as soon as possible. The registered manager showed us that the service had a complaints policy and had a system in place to record any feedback raised, whether positive or negative. We saw that the policy ensured that complaints were fairly listened to and action would be taken to resolve any issues raised.

Requires Improvement

Is the service well-led?

Our findings

As part of this inspection, we reviewed the quality assurance processes used by the provider to monitor and review the delivery of care to people. We found that there were some shortcomings in the internal systems in place which had not identified the areas of concern that we found. During our review of people's care records it became apparent that there were issues in respect of the maintenance of people's care records and in how staff recorded information within people's daily records.

Staff told us that they relied on the information provided within people's care plans, to care for people in conjunction with their practical knowledge. As this information was not always current, any staff that were not familiar with the service providing care and support would not always have appropriate information upon which to deliver suitable care.

People had care plans and assessments that detailed their care needs but we found that some had not been reviewed since February 2016. Not all of the care plans we reviewed had been evaluated on a regular basis, in accordance with the provider's expected processes. Where we had found that people's needs had changed, for example in respect of medication or mobility, these changes had not been taken into account in updated care plans or risk assessments. There had not been an impact to people because of this omission but it meant that the care plans were not always reflective of people's current needs.

In some care plans, we found that accidents and incidents had not been cross referenced within the progress and evaluation records, which meant that appropriate action may not have been taken by staff when attending their needs. For example, where bruising was found, this had not been fully detailed within the progress records. It was not always easy to determine what action had been taken to address this.

The registered manager told us that audits were completed, some of which had arisen from our previous inspections. Although we found that the service had monitoring systems in place, we identified that these had not always been used as effectively as they could have been. We found that despite the service having had regular audit checks of care plans, this had not identified that care plans did not always contain current information about people's needs. This demonstrated that the mechanisms in place to ensure quality delivery of care were not always applied as effectively as they could have been.

The recent absence of the registered manager had caused an impact to the normal working ethos within the service and to the overall managerial oversight of all required audit checks. We spoke to the registered manager about this. They informed us that they were committed to working with staff to make improvements to the service and to help them to feel secure in their roles and be involved in the running of the service.

The registered manager told us that they planned to conduct a satisfaction survey for people and their family members, to collect their opinions of the service and see if there were any areas which they needed to work on. They explained that this had not been carried out since our last inspection, but we saw from looking at past surveys, that there was no formal analysis of the results and no action plan as to how to use

the outcome to help drive improvements at the service.

The registered person had not consistently implemented effective systems or processes to assess, monitor and improve the quality and safety of the services being provided. This was a breach of Regulation 17 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to this inspection we had communicated with the local authority and Clinical Commissioning Group (CCG.) We found that they had also identified the same issues that we had found during our inspection; therefore the areas of feedback we gave to the registered manager came as no surprise; as they were already aware of them from other agencies visits. We discussed this with the registered manager and were assured that timely action would be taken to address these issues now that they had reduced the amount of night shifts they worked. Plans were also in place to recruit to the vacant deputy manager post, where it was hoped that this would give an additional layer of oversight in respect of management. They told us that they would work with the local authority and CCG to address the issues and make the required improvements.

Plans were in the process of being implemented to further develop staff skills and knowledge; two nurses had been identified as medication champion and care plan champion. They would focus on these areas and start to make changes to the systems in place.

There was a registered manager at the service. People and their family members were aware of who the registered manager was and were able to see them at the service when required. Members of staff told us that the registered manager worked openly with them and was always receptive to their comments or concerns. One staff member said of the registered manager, "We have a wonderful manager. We are really taken care of by [Name of Registered Manager]." We found that there was an open-door approach to the registered manager's office, so that staff could approach them to share any ideas or issues they may have. Another staff member said, "I get good support from the manager. I find her I can ask her for anything."

The registered manager was aware of their regulatory obligations to report certain incidents, such as safeguarding concerns or disruption to service delivery. Our records confirmed that the CQC had received statutory notifications from the registered manager.

There was a positive and open culture at the service. Staff members were motivated and keen to meet people's needs at the service. They told us that they felt they were able to meet people's needs and enjoyed the challenge of working at the service. We observed that staff were positive in their interactions with people and worked together to make sure their needs were met.

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 Care and treatment of people living at the service did not always reflect their preferences or meet their specific needs. Care plans were not person-centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided or planned with people's consent. Where people were unable to consent or make decisions about their care, the principles of the Mental Capacity Act 2005 had not been adhered to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments did not reveal a full understanding of the risk assessment process, or of the necessity to provide robust control measures to mitigate risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not operated effectively to ensure that people were protected from potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not consistently implemented effective systems or processes to assess, monitor and improve the quality and safety of the services being provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not sufficient in numbers to meet people's needs in a safe and appropriate manner. They were also not provided with sufficient supervision to ensure they had the knowledge, skills and support to perform their roles.