Sanctuary Care Limited

# Highcroft Hall Residential Care Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

The inspection took place on 10 and 11 January 2018 and was unannounced. At the previous inspection on 16 August and 18 September 2017, the provider was found to be in breach of Regulations 12, 17 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 and was rated as Inadequate overall. At the last inspection we found significant shortfalls in the provider's systems to assess and manage risks to people who were at risk of falls. This had left people at risk of serious injury. We found further shortfalls in the number of staff available for people and the governance systems in place.

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

Highcroft Hall accommodates a maximum of 52 people in one adapted building. At the time of the inspection there were 40 people living at the home.

There was not a registered manager in post. The previous registered manager left their role in December 2017. A new manager had been recruited and was in the process of completing their induction. They had submitted an application with us to register. 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 overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Risks to people who were at risk of falling were not identified or managed to keep people safe and this left people at risk of serious injury. Staff moving and handling practices were unsafe and people were being supported in a way that could put them at risk of harm. People had extended waits for support as there were not always sufficient numbers of staff available to support them. There were errors in the recording of medications that meant we could not evidence that medications had always been given to keep people well. Staff had been recruited safely and staff knew how to report concerns of abuse.

People who were at risk of weight loss did not have their weights or dietary intake monitored effectively to ensure that concerns could be addressed. People were not always referred to healthcare services in a timely way and where healthcare professionals had made recommendations, these were not always followed to ensure people were supported to maintain their health. People's rights were upheld in accordance with the Mental Capacity Act although staff knowledge of this varied.

People were supported by staff who were caring in their interactions with people but did not spend time with people when able too. Staff interactions with people had been limited to when care was being provided and people spent long periods with little stimulation. People were not always treated with dignity. People were given choices and supported to remain independent where possible.

There was a lack of activities available for people. People did not always feel involved in the review of their care but this was being addressed by the manager. Where complaints had been made, these had been investigated in line with the provider's procedures.

Audits were completed but had not identified the significant concerns we found at this inspection. The provider had failed to act on feedback where this was provided. Staff felt supported by the new manager.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Risks to people were not managed to ensure they were safe.

There were not always sufficient numbers of staff available to support people.

We could not evidence that medication was given as required due to errors in recording.

### Is the service effective?

**Requires Improvement**

The service was not effective.

The training staff received did not always provide them with the skills required to support people.

People who had been identified as at risk of weight loss were not supported to manage this.

People did not always have support to access healthcare services in a timely way.

People had their rights upheld in line with the Mental Capacity Act but staff knowledge on Deprivation of Liberty Safeguards varied.

### Is the service caring?

**Requires Improvement**

The service was not caring.

Staff interaction with people was limited to when care was being provided.

People were not always treated with dignity and communication needs were not always met.

People were supported to maintain their independence where possible.

### Is the service responsive?

**Requires Improvement**

The service was not responsive.

People were not consistently involved in reviews of their care but this was being addressed by the manager.

There were a lack of activities available for people.

Complaints made had been investigated and resolved.

## Is the service well-led?

**Inadequate**

The service was not Well Led.

Audits were completed but had not identified the concerns we found at this inspection.

Feedback given had not always been acted upon.

Staff told us they felt supported by the new manager.

# Highcroft Hall Residential Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 10 & 11 January 2018 and was unannounced. The inspection was prompted by information received from the provider about two incidents that had occurred at the service since the last inspection that resulted in people suffering serious injuries. We were aware from the previous inspection that there had been a number of incidents in the home that had resulted in people falling and experiencing serious injuries and that the local authority for this service is investigating some of these incidents. We used this information to plan areas to focus on during this inspection.

The inspection team consisted of three inspectors, a specialist advisor who was an Occupational Therapist and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority who commission services to gather their feedback. Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We spoke with five people who lived at the home. As some people were unable to share their experiences of the care provided, we completed a 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 four relatives, three members of care staff, the head chef, the newly appointed manager, the care development manager, the regional manager and the Director of Operations.

We looked at care records for 11 people, nine medication records, three staff recruitment files and records held in relation to quality assurance, accidents and incidents and complaints.

Inadequate

# Is the service safe?

## Our findings

At our last inspection in August and September 2017, we found significant shortfalls in the provider's systems to ensure risks to people were managed to keep them safe and to provide appropriate staffing levels. This resulted in breaches of Regulation 12 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 and provider was rated as Inadequate in the key question of Safe. At this inspection we checked to see if improvements had been made and found that people remained at risk from staff who did not recognise or act on risk.

At the last inspection, we found that the provider's systems to manage and reduce the risk of people falling had been ineffective. This had resulted in a high number of people falling and sustaining serious injuries. At this inspection we found that these concerns had not been fully addressed and people remained at risk of injury.

We identified a number of people who were at risk of falls and looked at the care they received. We found that although some referrals had been made to falls teams and occupational therapists where risks were identified, the provider had not taken further action to mitigate risk whilst they awaited further support. For example, we saw one person who was at risk at falling from their chair. We saw from records that this person had previously experienced a number of falls from chairs and staff were aware of this risk. However, we observed this person sitting in a way that increased their risk of falling and staff failed to take action to ensure this person was safe. Inspectors intervened and requested that staff support the person to sit in a safer position. The person shortly returned to the unsafe seated position, but staff again failed to act to ensure the person's safety. We saw two other people also seated in the communal areas in a way that would increase their risk of falls. Staff were present while people were sat in this way and did not act. This increased the risk of the person falling as the staff had not identified this as a concern or taken action to keep the person safe.

Where risks to people had been identified, referrals had not always been made. We saw one person who was supported to stand in an unsafe way. The staff spoken with acknowledged that this was unsafe and that they had requested that the moving and handling trainer reassess the person. The trainer had not taken this action and told us, "When I returned the next day [person's name] was fine and so I did not bother to assess them". This meant the person continued to be standing in an unsafe way as staff did not take action. This meant that staff had failed to identify and act where falls risks were present to ensure people's safety.

We found that staff were using unsafe practices to support people to move that increased their risk of falls. We observed staff support one person to stand. The staff supporting advised the person to pull themselves up using their frame. This is unsafe and increases the risk that the person may fall. When staff were asked about why they were supporting the person in this way, they informed us that this was because it was how the person liked to be supported. The staff had not risk assessed this or explained to the person why this was not safe and had continued to support them in this way. We observed a second person being supported to stand using the stand aid. The person did this by holding onto the sling, rather than the handles of the stand aid. This is an unsafe way for the person to stand. The staff moving and handling trainer was present

for this transfer and they advised us that they believed this was a safe way to support the person. This meant that the moving and handling trainer; who had responsibility for training all other staff in safe moving and handling, had been unable to identify poor practice.

We found that some equipment used to support people to move was not in good condition. A sling that was being used to support a person was visibly worn and had tears. This should not have been used to support people but staff had not checked this prior to use and so continued to use this. We found that one stand aid had a safety catch missing which increased the risks of the slings slipping off the stand aid. This had the potential to cause injury to people and had not been identified by the provider or the staff using the equipment.

Risk assessments completed in relation to falls were not always detailed or accurate. For example, one person's fall risk assessment identified that they only required one member of staff to support them with transfers but staff spoken with told us that they required two. Another person's risk assessment recorded that staff should ensure the person's bed was at its lowest height setting to reduce the risk of falls, however when we checked we found that the person's bed was not height adjustable and so this action could not be taken. A third person had been assessed as being at high risk of going missing but the risk assessment for this had been left blank and there was no information for staff about how they should reduce this risk. This meant that the risk assessments completed had not accurately assessed people to ensure they could be supported in a safe way.

We found that other risks had not always been managed to keep people safe. We saw that one person had pressure areas on their skin. This was being treated by visiting district nurses who had advised staff in December 2017 that to reduce the risks to the person they should be supported to reposition every hour. We checked daily records completed by staff and found that this was not being done consistently. We found that the majority of entries showed that the person was being supported every two hours. The record sheets used to record this information held conflicting information on how often the person should be supported with some sheets informing staff to support hourly and others stating two hourly. This meant that the person had not always been supported with their pressure care as directed by health professionals. This increased the risk of the person developing sore skin. We raised this with the care development manager who informed us they would address this with the staff team.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave varied feedback when asked if there was enough staff to support them. One person told us, "There seem to be enough carers when I need them". Another person said, "It varies as to whether there are enough carers". A relative added, "Staffing levels are sometimes an issue". A second relative told us, "No, there is not enough staff, particularly at night". The relative went on to inform us that their loved one had extended waits to be supported to the toilet at night as staff were supporting other people. One person told us they had not always been able to have a shower when they wished due to a lack of staff. The person told us, "I asked if I could have a shower on a Saturday when it is quieter but I haven't been able to sometimes as there aren't enough carers".

This was confirmed by staff who also felt that there were not enough staff to support people. One member of staff told us, "In my opinion, there is not enough staff. Ground floor is ok but the other two floors have more people at risk of falls and it is more pressurised". Another member of staff said, "There is sometimes enough staff. When someone calls in sick, it's pressurised".

We observed that staff were visible throughout the day; however the staff were not always deployed effectively to ensure people were safe and responded too in a timely way. For example, we heard one person in their room call their emergency buzzer for support. We located where the person was and saw that no staff were attending to support them. When we entered the communal areas, we found a group of four staff talking in the kitchen. The buzzer was audible from the kitchen but no staff had responded to this call. One member of staff from the group responded to the buzzer when we entered the kitchen. This meant that the person had an unnecessary wait for support as a number of staff were available in the communal areas but had not responded to the persons call. Another person told us they had to wait for their medication as there was no staff. The person said, "It is the afternoon now and I am still waiting for my morning medication". We saw a staff member arrive to give this medication and apologise for the delay in supporting with this.

We spoke with the director of operations who informed us how the staffing levels were decided upon. They explained that this was based on the layout of the building and the broad provision of care that the location is registered to provide. This meant that although staffing levels were assessed, it was not clear that this was individual to the needs of the people using the service. For example, we found that two people who were at high risk of falls had been sleeping in chairs across two communal lounges at night. This had not been taken into account when assessing the staffing levels at night. We asked the regional manager how they ensured the people sleeping in communal areas were safe when staff were supporting people elsewhere in the home and they informed us that staff would be called from another floor of the home to help. However, this then would leave other floors short of staff and lead to extended waits for people on those floors. This had not been considered when assessing the number of staff required during the night.

People we spoke with raised concerns about a high number of agency staff being used when permanent staff were not available. One person told us, "A lot of the night staff are agency and they don't seem to be very well trained". Another person said, "There is quite a lot of agency night carers, nearly every night". A relative added, "I believe at night there are a lot of agency carers and I think it bothers my relative as she has mentioned it a few times". We looked at rotas held and found that agency staff had been used at night on 11 out of the previous 21 days. We spoke with the care development manager about this who advised that this was due to a high number of staff sickness and that they had reduced the impact on people by ensuring the same agency staff were used where required. However this action had not reduced the concerns expressed by people who did not feel the staffing at night was sufficient.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the support they received with their medication. We observed staff supporting people to take their medication and saw this was done in a safe way. The staff member told the person that it was time for their medication and stayed with them while this was taken. We saw that medication had been stored safely and that room and fridge temperatures were checked daily to ensure that medication was stored at the correct temperature. Some people required medication on an 'as and when required' basis. We saw that there were protocols in place advising staff on when these should be given. We looked at medication records and could not always see if medication had been given as required. For four of the medications checked, the amount of tablets recorded as being given did not match the number of tablets available. This meant that we could not be sure if medications had been given. For one person's medication, we found conflicting information on how this should be given. The Medication Administration Record (MAR) directed staff to give this medication daily. However, the pack in which the medication was stored stated that this was to be given 'as and when required.' This meant there was a risk that these medications would not be given in a consistent way as the information provided to staff was not clear. We raised this with the manager who provided assurances that these medication errors would be

investigated immediately.

We found that all staff had completed training in Infection prevention. The home was clean and tidy and there was a domestic team in place to ensure the cleanliness of the home. We saw that personal protective equipment (PPE) was available and that staff used these appropriately to prevent infection when supporting people. One member of staff told us, "I wear gloves, aprons and use hand gel to prevent cross contamination". However, we observed one member of staff during mealtime, handle food without wearing any disposable gloves. The staff member picked up a person's food with their bare hands, placed this on a plate and served this to the person. This was not in line with current best practice guidance surrounding food safety. We raised this with the manager at the end of the inspection and they informed us they would address this.

People told us that they felt safe at the home. One person told us, "I always feel in safe hands when the carers are helping me get in and out of bed". Another person said, "I do feel safe". We saw that staff had received training in how to safeguard people from abuse and knew the action they should take if they had a concern that someone was at risk. One member of staff told us, "If I witnessed abuse I would intervene, report it to my senior and report it to CQC". We saw that where concerns were raised, the manager had acted and reported this as required to the local authority safeguarding team. However, as the manager had not identified the unsafe practices in relation to moving and handling, these has not been referred as a safeguarding concern to ensure that people were safe.

There were systems in place to reduce the risk of unsuitable people being employed. Staff told us that before they started work, they had been required to provide references from previous employers and complete a check with the disclosure and barring service (DBS). The DBS check would show if a person had a criminal record or had been barred from working with adults. Records we looked at confirmed that these checks took place.

The manager told us they aimed to ensure they learned from incidents that occurred at the service but we did not see this happen in practice. We found that a number of concerns found at this inspection in relation to people being at risk of falls and staff poor moving and handling practices had been raised with the provider previously and the managers had informed us these had been addressed. However, we found that these issues remained and that lessons had not been learned from the concerns raised previously. This meant that although the management team felt they had learned from past concerns, this had not been evidenced in practice and many of the risks raised previously, remained and this had left people at risk of harm.

Requires Improvement

# Is the service effective?

## Our findings

We found that people's needs had been assessed prior to moving into the home. We looked at people's care records and saw that initial assessments took place and addressed a number of areas including; medical History, personal care needs and dietary needs. We could not see evidence from the assessments that people had been asked about their needs in relation to any protected characteristics under the Equality Act; such as religious needs or sexuality to ensure that needs in relation to these areas could be considered when care planning.

People felt that staff had the skills to support them. One person told us, "They [staff] seem knowledgeable and well trained". A relative added, "They [staff] are knowledgeable".

Staff told us that before they started work, they had been required to complete an induction that included completing training and shadowing a more experienced member of staff. However staff had not always completed a full induction. One member of staff told us, "Induction lasted one or two days. I didn't really do any shadowing". Another member of staff told us, "I shadowed a senior on induction for around a week". However, this staff member went on to say that they had not received training in a number of areas that are important to providing care such as Safeguarding. This meant that not all staff had received their full induction in order to equip them to support people effectively.

Staff told us they had received training to enable them to support people effectively and the records we looked at confirmed this. However, the training provided in Moving and Handling had not provided staff with the skills needed to support people. We observed a number of unsafe practices completed by staff; all of whom had completed this training in this area in the previous 12 months. This meant that the training provided had not been effective in providing staff with the skills and knowledge they required as they had not evidenced these skills in practice. This training was given to staff by other staff members who had been on accredited 'Train the Trainer' courses in Moving and Handling. We identified concerns around the competency and knowledge of the members of staff responsible for providing the moving and handling training to staff and was informed by the managers that this would be looked into. Following the inspection, we received information from the provider that they had begun the process of re-training staff in Moving and Handling using a second member of staff trained to do this. Staff told us that they were now receiving supervisions in which their personal development could be discussed. One member of staff told us, "Recently there has been more supervision".

People gave mixed feedback about the meals they were offered at the home. One person told us, "The less I eat here the better. I have made complaints about the food but nothing has happened about it". A relative we spoke with said, "The meals are horrible. We have bought in food for [person's name]". Other people spoke more positively about the food with one person telling us, "The food is adequate".

We saw that people were given choices at mealtimes. However these choices had not always been respected and where people requested an alternative to the menu, this was not acted upon. For example, we saw one person request a meal of just broccoli. The person had spoken with staff and said they did not

want any mash on their meal. Staff returned shortly after with a plate of vegetables and mash and told the person, "The kitchen has done this for you now, just leave what you don't want". This meant that the person's requests had not been met.

Mealtimes were quiet with little interaction between staff and people while they ate. However, where people required support to eat, this support was provided by staff. One person told us, "They [staff] come in and help me to drink when I need them too".

We saw that some people had specific dietary requirements. For those who required soft food or diabetic meals there was a noticeboard in the kitchen notifying staff of these dietary needs. However, for one person who required fortified meals, we could not see this information displayed. We spoke with the head chef about this who informed us that they do not fortify food for any person. This meant we could not determine if this person's dietary needs were being met as the kitchen staff were not aware that this person required a specific diet.

We identified that a number of people had been losing weight. We asked the care development manager how they ensure that people who are at risk of weight loss are monitored and referred to healthcare services where required. The care development manager informed us that people were weighed monthly and that if a person experiences weight loss of four kilograms or more then they would begin to monitor food and fluid intake as well as commencing weekly weight monitoring. However, we found that for four people who had lost over four kilograms in previous months, no monitoring of their intake or weights had been taking place. This meant that the provider had failed to implement their own procedures to ensure people at risk through weight loss were effectively supported and monitored.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had access to healthcare services as required. One person told us, "The doctor comes once a week or if I want them. The district nurses come too when required". We saw a number of district nurses visit people through the day and records we looked at showed that people had been visited by the optician. However, we saw that where people would benefit from healthcare services these referrals were not always made. We identified a number of people who had been losing weight over a period of time but had not been referred to have this investigated. One person had lost weight consistently from August to December. However a referral for dietician support was not made until January 2018. A relative we spoke with also raised concerns about the provider's ability to act on health concerns in a timely way. The relative told us, "I wouldn't say the staff are proactive in getting to the bottom of what is going on [with person's name's health]. It has been more me asking them to get a GP". This meant that the provider had not acted in a timely way to ensure the person had access to healthcare input to improve people's health and wellbeing.

We also found that staff had not always acted on the advice given by health professionals. We found that a Community Psychiatric Nurse had requested that staff start completing a chart to monitor when a person walks around. The request was made in November 2017. We asked staff to see these completed charts and were informed that these were not completed. This meant that staff had not acted on the advice of health professionals in order to support a diagnosis and improve the person's health and well-being.

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 authorisation 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.

People told us that staff sought their consent before supporting them. One person told us, "They [staff] always check with me". Staff we spoke with understood the importance of obtaining consent. One member of staff told us, "I gain consent by talking. I ask them if it is ok". Staff told us and records confirmed that staff had received training in MCA and we saw them put this into practice. We spoke with the care development manager who acknowledged that previously there had been no systems in place in relation to MCA. The care development manager informed us that she was working to address this and had commenced a full review of each person's capacity. We saw that the managers had completed Mental Capacity Assessments for people and that where required, best interests meetings had been held. The details of these were held in people's care records. Where people had appointed a Power of Attorney, the managers had copies of these documents to ensure they were aware of who held this responsibility.

A number of people living at the home had DoLS in place. We were made aware by the care development manager that a number of applications for DoLS had been made inappropriately as the person had capacity to make decisions and so a DoLS was not required. The managers were working to address this and ensure that only those who required a DoLS had applications submitted. The staff we spoke with did not always know who had a DoLS and why.  Without the knowledge of who required a DoLS authorisation, we cannot be sure that staff act in line with this and any associated conditions. We raised this with the managers who advised they would address this with the staff team.

People told us that they felt the communication between the staff and other organisations was good. One person told us, "Communication is very good, here within the home and amongst other organisations, such as nurses and GP's". Staff also felt the communication systems were effective in giving them the information they required. One member of staff told us, "If someone is new, we are told about their risks and needs in handover. There is a handover every shift".

We saw that following recommendations from the falls team, the provider had taken action to ensure that the home's decoration and design met people's individual needs. They had ensured that grab rails in hallways were a separate colour to the wall to support people in identifying where these were. We saw that communal areas were bright and spacious and people's own bedrooms were clearly signposted with pictures of the person to support them to find their own bedroom. This meant the provider had ensured that the decoration of the home supported people's individual needs.

Requires Improvement

# Is the service caring?

## Our findings

People gave mixed feedback when asked about the caring nature of staff. One person told us, "They [staff] are always very willing and helpful and they seem to really care". Other people raised concerns and one person told us, "Some of the staff are really good and I get on really well with them, but if some of them have a bad time at home they struggle to put a smile on". A relative we spoke with added, "The carers don't know how to talk to people".

We saw that when staff were spending time with people, they appeared to have friendly relationships with the people they were supporting and spoke to people in a kind way. However, the interactions with people were limited to when support was being provided and we saw that where people didn't require help, staff did not spend time with people. We saw there were occasions where staff were in the communal areas and could have been spending time with people, but we found the staff group were sat together in the dining area instead. We saw staff sitting amongst people discussing their personal interests with each other. Staff did not attempt to involve people in these conversations and people remained sat with no interaction from staff while these conversations were ongoing. This had been identified by some people and one person told us, "Adjustments need to be made perhaps in the area of having time to stop and chat". This meant that opportunities to spend time with people were available but had not been utilised by staff.

People did not always have their communication needs met in their preferred way. We found that one person did not speak English as their first language. Staff communicated with the person using the limited English that the person knew. However, there were members of staff working at the home who did speak this person's language but they had been allocated to work in another area of the home; meaning they never worked with this person. We raised this with the manager and asked why this hadn't been identified as an area in which the person's communication needs could be better met. The manager informed us that this is something they had identified since commencing their role and intended to address the staff allocations so that the person could be supported by a staff member who speaks their preferred language where possible.

People told us they felt treated with dignity and were given privacy when requested. One person told us, "Carers are respectful and mindful of my dignity and privacy. They knock and ask before they come in". We observed staff knocking on people's doors and awaiting permission before entering a room. Staff we spoke with could also demonstrate how they ensure privacy and dignity. One member of staff told us, "I make sure I close and lock the door when supporting with personal care, talk to the person and ask if I am ok to help them". However we saw an instance where a person's dignity had not been respected. Staff spoke to a person in the communal area and asked loudly, 'Do you want to go to the toilet?' This was not dignified for the person as all of the other people in the room could clearly hear the question and that she required support with this task. We raised this with the manager who advised they would address issues around dignity with staff. This meant that although staff were aware of how to promote people's dignity, this had not been consistently practiced.

People told us they were given choices and were involved in their care. One person told us, "I go to bed and

get up when I want". Another person told us, "I go to bed when I want and I get up when I want and I have my meals where I want". We observed people being given choices throughout the day, such as where they would like to sit and what they would like to drink. People also felt that they were encouraged to maintain their independence where possible. One person told us, "The carers always encourage us to do as much as we can and be independent but if we need help, they are available". Staff we spoke with understood the importance of promoting people's independence. One member of staff told us, "We encourage people to do as much as possible for themselves". Another staff member gave the example of encouraging people to walk independently for as long as they are able.

The manager told us that no-one currently living at the home had the use of advocate. An advocate can be used when people may have difficulty making decisions and require this support to voice their views and wishes. We spoke with the manager about this and they understood when an advocate may be required and how they could refer people to this service if required.

Requires Improvement

# Is the service responsive?

## Our findings

Some people spoke positively about the activities they engaged with. One person told us, "I have been to the garden centre, we play skittles and there is a man that comes in to do exercise". Another person said, "The activities here are better than Butlin's". However, other people felt there were not enough opportunities to take part in activities. One person told us, "I get involved in any activities or going, but there isn't a lot going". This was confirmed by a relative who told us, "People sit there all day, no activities, no interaction, they just sit there". We found very little activities taking place during the inspection; we found people sat in communal areas for extended periods of time with no activity and little interaction from staff. We found this varied between communal areas and that some communal lounges were more active than others. We found that where staff were available and could have supported people to take part in an activity, this had not happened and that staff interaction with people was task focussed. This meant that although some people were satisfied with the activities available, people were not able to consistently access activities that met their personal interests and hobbies. We also did not see any evidence that people were supported to make links with the local community and access activities outside of the home.

People gave mixed feedback when asked if they had been involved in the planning and review of their care. One person told us, "I have had my care plan rewritten as there have been some changes in my care needs and I have been asked about it". Other people had not been involved and one person said, "I have got a folder in my room, I don't know what it is about and I haven't been asked about how I want my care delivered". Relatives we spoke with informed us that they were now beginning to get involved with reviews of care as the new manager had invited them to join these. One relative told us, "We had never been invited to a review before today". Records we looked at showed that people's care needs had been assessed when they moved into the home and that these were reviewed regularly and we saw that the new manager was contacting relatives and inviting them to become involved in reviews moving forward. That meant that although not all people told us they were involved in reviews of their care, this had been identified by the manager and action was being taken to address this.

People told us that staff knew them well. Staff we spoke with displayed a good understanding of people's likes, dislikes and preferences with regards to their care. We saw that records held personalised information about people including dietary preferences such as preffered portion size. Some care plans held life history books that gave details about the person's history, family and work life. We saw that people had care plans in place relating to their wishes at the end of their life. These care plans showed that people had been asked about any specific requirements they would like met if they were in receipt of end of life care. For example, these care records showed that people were given opportunity to say where they would like to be cared for at the end of their life and any family members they would like with them.

People told us they knew how to complain. One person told us, "If I had any concerns I would ask to see the manager". A relative we spoke with told us they had previously encountered issues when making complaints and had not felt listened too. However, they had felt that the care development manager had since been more proactive in dealing with their complaints. The relative told us, "[Care development manager's name] dealt with it and gave us feedback. We had never, ever got feedback before". We saw that there was

information displayed in communal areas on how people could make a complaint if needed. However, we could not see that this was available in other formats, such as easy read or braille, for those that required this. We spoke with the managers about this who informed us that while alternative formats were not available, they had a team of staff who were able to produce documents in the required format should people require them. We looked at the records held on complaints and saw that where complaints had been made, the provider had investigated these and provided a response to the person making the complaint.

Inadequate

# Is the service well-led?

## Our findings

At our last inspection in August and September 2017, we found significant shortfalls in the provider's systems to ensure risks to people were identified and acted upon and found that audits completed were ineffective in identifying where action was needed. This resulted in a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 and a rating of Inadequate in the key question of 'Is the Service Well Led?' At this inspection we checked to see if improvements had been made and found that people remained at risk as a result of ineffective governance systems.

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We saw that there were systems in place to monitor the quality of the service. This included monthly audits completed by the manager that addressed areas including Medication, Care Planning and infection prevention. Further audits were then completed by the regional manager each month to sample the home manager's audit and verify the identified actions from this. The provider's quality team also completed a six monthly audit of the home. We saw that these audits had been completed consistently and that where areas for improvement had been identified, actions were recorded to address these.

However, the audits had failed to identify the significant concerns we found at this inspection around the management of falls. The provider had made referrals to the falls team and other health professionals where required, however they had failed to act and ensure that risks were managed by staff whilst that support was gained. We observed staff complete a number of unsafe moving and handling practices that the provider had not identified. The provider had failed to implement systems to ensure that the training provided by their own trainers was effective and resulted in good practice. This had led to people being exposed to risk of harm as staff had not been adequately trained in this area and were placing people at risk with their practice.

The provider had also not ensured that records held in relation to falls risks were accurately maintained. We identified care records where the information held in relation to falls was incorrect or missing. Care plan audits had taken place as part of the manager and regional manager's audits, but these issues in recording had not been identified. This meant that the audits completed had been ineffective in ensuring that accurate records were maintained.

We identified that following the last inspection, referrals for falls support were made for everyone living at the home. Some of the people referred for this support had no history of falls and so these referrals were not appropriate. This raised concerns about the provider's understanding of falls management and their ability to effectively assess and act on people's care needs in relation to mobility and falls.

We found that people were not always supported to access healthcare support in a timely way. People who were identified as being at risk of weight loss had not received support to have this investigated. The care plan audits completed had not identified the people who were at risk and so action had not been taken to ensure they were seen by health professionals. Where people had received input from healthcare services, the provider had failed to ensure that staff acted on the advice given.

The provider had a system in place to assess the number of staff required to support people. However, we could not evidence that this was individual to the needs of people living at the home and that this was being reviewed regularly. The provider was unaware of people's concerns about staffing levels and the high use of agency staff. People expressed to us that they did not feel there were enough staff to provide their support and that they often had extended waits for support. We informed the provider of these concerns. The provider contacted us following the inspection and informed us that following our feedback they had reviewed staffing levels following our visit and felt that the current staffing levels were sufficient and would not be making any immediate changes to the current staffing numbers.

The provider had not identified that people were having extended waits for support when they used their emergency call bell. The director of operations informed us that there was an IT system in place that would inform them how long people had waited for support when their call bell rang but that this had not been utilised to ensure that people were receiving support in a timely way. The director of operations contacted us following the inspection to inform us that the monitoring of call response times had now been added to the manager's monthly audits.

At the last inspection, the provider was found to be in breach of Regulation's 12, 17 & 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider informed us they had learnt from that inspection. The director of operations told us, "We know that in the summer there were people who shouldn't have been here, we appreciate that at that time we hadn't reviewed staffing well enough and that people were inappropriately reviewed". The provider was confident that these breaches had now been met. The provider informed us and the local authority who commission care at the home confirmed that work was ongoing to ensure that improvements could be made. However, we did not see that sufficient action had been taken to ensure people were safe and people remained at risk of harm. This demonstrated that the provider lacked oversight of the scale of poor moving and handling practices amongst staff and the lack of systems to manage and reduce falls risks to people. The provider had also failed to address or act on people's concerns around the numbers of staff available to support them. This had left people at risk of harm.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager of the home had left their position in December 2017. A new manager had been recruited and was completing their induction at the time of the inspection. People we spoke with were aware of who the new manager was. One person told us, "I have met the manager; she came and chatted with me for a while". Another person said, "I never saw the old manager but I have met the new one, she has come and said hello". We saw that the new manager was taking steps to introduce herself to people and their relatives and had arranged meetings to formally introduce herself.

Staff told us they felt supported by the manager and were confident that any issues they raised would be addressed. One member of staff told us, "The new manager has a positive attitude". We saw that the managers had responded too and informed us of incidents that occurred at the service as is required by law. All staff we spoke with were aware of how to whistle blow if they needed too.

We saw that people were given opportunity to provide feedback on the service through service user meetings. However we saw that some feedback in relation to meals had not been acted upon. We saw that meetings were being held for relatives and residents with the new manager and people spoke positively about this.

It is a requirement that providers ensure that their most recent rating is displayed within the home and on any websites ran by the provider in relation to this home. We saw that the provider had displayed their rating on both their website and in the reception area of the home and so had met this requirement. The provider had also ensured that they informed us of incidents that occurred at the service as is required by law.