Higher Park Lodge Limited

Higher Park Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place over three days, 21 December 2015, 7 January 2016 and 21 January 2016. The first day of the inspection was unannounced.

The service provides care for and accommodation for 34 people who are living with dementia or who may have physical or mental health needs. On the days of the inspection 33 people were living at the care home.

Higher Park Lodge is on three floors, with access to the lower and upper floors via stairs or a passenger lift. There are some shared bathrooms, shower facilities and toilets. Communal areas include a lounge, a reading room, a dining room and an outside patio area.

The service had a registered manager in post. 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.

At the last inspection on 27 and 29 May 2015, we asked the provider to take action to make improvements as we found care was not always safe, personalised and consistent; people's privacy was not always respected; people's consent was not always obtained prior to care being given; risk assessments did not always reflect people's needs; there was no proper and safe management of medicines; effective systems were not in place to take action should an allegation of abuse be received; staff did not always have the knowledge, experience and skills to support people; and the systems in place to monitor the quality of the service were ineffective. The provider sent us a plan detailing the improvements which would be made to meet the legal requirements in relation to the breaches. The provider told us they would make improvements by the beginning of October 2015.

At this inspection we found some improvements had been made, but we continued to have concerns in several areas.

Prior to the inspection we received information of concern about the service. These included concerns about people's care; care not being given as people chose; lack of care planning in respect of people's specific needs and staff not accurately recording people's day to day care. We reviewed these concerns, along with the issues raised at the previous inspection, during this inspection.

People's medicines were not always managed and administered safely. Some people told us they were not always observed taking their medicines and we found staff were signing the person's medicine administration records (MARs) without staff knowing people had safely taken their medicine. There were gaps in people's MARs so it could not be guaranteed people had been given their medicine as prescribed. Staff were not always clearly recording people had their prescribed creams applied as directed. Storage of medicines was not always safe and we found discrepancies in other records concerning how people's

medicines were given.

People's care records were not always personalised and did not always show whether people were involved in writing them. However, these were being improved during the inspection. People did not always receive their personal care as they wanted it delivered. The records of people's care were not always complete and lacked essential details to ensure care given was appropriate and as desired by the person. People's end of life needs were not always planned with them and the care planning was inconsistent.

People's individual risk assessments were not reviewed regularly to ensure they reflected people's current risk. People were not involved in planning how to mitigate the risks they faced while living at the service. People's care plans and records did not reflect risks which had been identified.

People were not always being assessed in line with the Mental Capacity Act 2005 (MCA). Not all staff had been trained in the MCA and the associated Deprivation of Liberty Safeguards (DoLS). When people did not have the mental capacity to make decisions about their care and treatment, assessments were not always evident and there was a lack of guidance in place for staff about how to support people to make decisions. However, we observed staff asking for people's consent before providing personal care.

Good leadership and governance was not always evident. The provider had developed new audits but not all of these were effective and had not identified the issues raised during the inspection. However, the provider was working in collaboration with external services to improve the quality of care.

There were some activities and outings which occurred at the home which people who liked participating, enjoyed.

Staff were recruited safely. Staff were receiving training and updates to meet people's needs. Staff had received safeguarding training and understood how to identify abuse and keep people safe from harm. However, staff did not always understand what was being asked of them. For example new daily checklists had been developed which were being completed but staff were not recognising where there were problems, for example mattresses were not always set correctly to people's weight but signed as checked. Staff had also worked hard to update care plans but we found they lacked the knowledge to develop care plans which reflected people's risks and care needs, for example how to manage people's diabetes, falls or weight loss.

People's health needs were met. People could access their GP and other health professionals as required. People received a healthy diet but where people required their food and drink intake to be monitored or their weight monitoring, the recording of this was not always accurate. This meant it was not possible to know if people had been eating and drinking enough to maintain their health.

There was a complaints policy in place. People's concerns were dealt with when they arose. People felt comfortable speaking to the registered manager if they had any concerns. People, staff and visitors felt they could speak to the registered manager and they were approachable.

The service was clean and infection control procedures were followed by staff.

There were systems in place to maintain the equipment and utilities at the service.

The service was working collaboratively with external agencies to improve the quality of care people received.

We found a number of breaches of the regulations. 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 were not always protected from the risks associated with their care and health conditions. Documentation did not always reflect people's care needs.

People's medicines were not always managed safely.

People told us they felt safe and staff had received safeguarding training.

There were enough staff to meet people's needs.

Safe recruitment practices were in place.

The service was clean and staff followed safe infection control policies.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always cared for by staff who had received training to meet their needs, however a programme of staff training was planned and in progress.

People were not always assessed in line with the Mental Capacity Act 2005 as required. People told us staff always asked for people's consent and respected their response.

Staff did not always have the knowledge, skills and training to meet people's needs.

People's nutritional and hydration needs were sometimes met. People received a good diet but where people required monitoring for health reasons, this was not always evident from the records kept.

People had their health needs met, people told us if they were unwell they saw their doctor quickly.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always seek people's advance choices and plan their end of life with them. This meant people's decisions about their end of life care may not be known by staff and they may not receive the care they wanted.

People told us they were looked after by staff that treated them with respect and kindness. People and visitors spoke well of staff. Staff spoke about the people they were looking after with fondness.

People felt in control of their care and staff listened to them.

People said staff protected their dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have care plans which were personalised and reflected their current needs. Care plans did not always give sufficient guidance and direction to staff about how to meet people's care needs. Staff had not read people's care plans and did not always know their care needs and preferences.

There were activities in place which people could engage with.

People felt able to talk to the registered manager about any concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems in place to monitor the quality of care had not identified all the issues raised during the inspection.

People, relatives and staff said the registered manager was approachable and visible.

There were systems in place to ensure the equipment and building were maintained.

The registered manager and senior staff were receptive to inspection feedback and working collaboratively with external agencies to improve people's care.

Higher Park Lodge

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.

The inspection took place over three days, 21 December 2015, 7 January 2016 and 21 January 2016. The first day of the inspection was unannounced and undertaken by two inspectors for adult social care. The second day of the inspection, 7 January 2016, was announced and was undertaken by two inspectors for adult social care, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The third day of the inspection was announced and undertaken by one inspector for adult social care.

Prior to the inspection we reviewed the information held by us from previous inspection reports and notifications. Notifications are reports on specific events registered people are required to tell us about by law.

Before the inspection we also sought feedback from professionals involved with the service. This included health and social care professionals and Healthwatch.

During the inspection we spoke with 24 people and six visiting family / friends of people who lived at the service. We asked them their view on the service and their care. We looked at the care of six people in detail to check they were receiving their care as planned. We spoke with them where this was possible. We looked at people's medicine management. We observed how staff looked after people in the lounge room and in the dining room at meal times.

We spoke with the registered manager, the cook and six care staff. We spoke with the registered manager about staff recruitment, induction and training processes. We reviewed the records kept on monitoring the quality of the service, audits and maintenance records.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in May 2015 we found risk assessments were not reflective of people's identified needs. The registered manager sent us an action plan advising us risk assessments would be updated and in place by the 1 October 2015.

During this inspection we found risk assessments were not sufficiently detailed to support people to live safely at the service. Not all people had risk assessments which were up to date or reflective of their needs and risks in relation to their skin care, falls or nutrition. In addition, identified risks were not clearly linked to people's care plans. For example one person who had a history of skin damage had a skin care assessment which identified them as high risk. There was no date on this assessment, no review noted and their care plan did not clearly describe how staff were to mitigate the risks to this person's skin. Another person who had lost over 10kgs in 11 months (55.6kgs in February 2015 to 44.5 kgs in January 2016) did not have a nutritional risk assessment completed or a care plan to guide staff how to support the person to minimise the risk of further weight loss.

People's falls and accidents were recorded in the accident book. Falls were monitored through a monthly audit and this had identified the increased frequency and number of falls one person was having. One person told us, "I've had loads of falls" going on to say they consequently had rails fitted to their bed to prevent them falling from bed. They told us, "I feel safer with it." Staff told us they considered pressure alarm mats or bed safety rails for people at risk of falling. For the same person, we saw an undated risk assessment, completed by the registered manager, for 'cot sides' with indication that this was being done because of the person's risk of falling from bed. It included their use had been discussed with the person because they kept unplugging their alarm mat. There was no risk assessment for the use of bedrails to ensure they were safe to use given the person's type of bed and mattress, or evidence that alternative support that had been discounted (such as regular checks by staff), to show this was the least restrictive option possible.

Two people who had fallen in the past told us staff checked them over for injuries before getting them up from the floor. Both people told us two staff got them up manually, without using a hoist, one describing how staff put arms under their armpits to lift them up. They told us "I put my shoulder out when I fell last time, and one of the carers put it back, it is still painful." The registered manager told us this person could be encouraged to get themselves up, by first getting themselves onto their knees, and they had not dislocated a shoulder. They told us the last time this person had fallen he was outside and paramedics attended. There was no guidance in these individuals' care plans as to how staff were to assist them up if they fell. Staff told us they always used a handling belt to assist people when they fell. Two care staff we spoke with had not had manual handling training which meant they might not know the correct ways of moving a person safely.

People with a diagnosis of diabetes did not have appropriate risk assessments in place to manage their condition and ensure staff could support them safely. Two people's care records we looked at had diabetes. One person had fluctuating blood sugar levels. Their care plans did not guide staff on the signs and symptoms they should look for to indicate the person might have very high or very low blood sugars, nor the

action staff should then take. One person's diabetic information indicated they should still be having daily blood sugar monitoring. Staff thought this to be the case, but the records said it had not been done since July 2015. The registered manager informed us this person no longer required their blood taken daily. Not having accurate information in people's care records could place them at risk of not receiving the care they require.

Not ensuring people's risks were fully assessed and mitigated is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection period the registered manager was working closely with the local authority to improve the assessment of people's risks and care plans. We saw an example of one care plan which was being completed by the registered manager and it was more detailed and thorough.

Staff were able to describe actions they would take if someone appeared unwell or injured. Staff told us they always rang the emergency bell if someone had fallen. This ensured a senior member of care staff attended and the person was checked before they were moved. The staff member told us they would complete the accident book, a staff communication folder (so other staff would be informed of the fall), as well as the person's daily records. If a person sustained an injury, the senior care staff were informed so they could complete a body map. Staff told us the home had two hoists, which could be taken to any floor of the home, should one be needed. During the inspection we observed staff moving people safely from their wheelchairs to their dining chairs.

We found body maps were not regularly completed, however a new body map form had been developed and the registered manager told us staff would be using it moving forward. This meant injuries, sores and bruises would be noted as they occurred. This helps staff assess and monitor people's skin condition to ensure healing is occurring.

At the previous inspection we found people did not always receive their medicines safely. The provider's action plan said staff had completed further medicines training. We were told medicine audits would be completed at six monthly intervals, a monthly checklist would be devised, and spot checks would occur. The action plan advised these would be in place by 1 October 2015.

Changes and improvements were being made to the way medicines were managed, however at the time of this inspection people's medicines were not always managed safely.

Medicines were stored in locked cupboards or trolleys; however the medicines refrigerator was not locked at the time of our inspection. It was within a locked office, and staff told us that the room was always locked when left empty, and we observed this during the inspection. However, staff needed to access this office regularly and this meant that these medicines were accessible to all staff and not just those authorised. The temperature in the refrigerator had not been recorded since 22 December 2015, although it was within the recommended range at the time of the inspection.

The medicine round we observed took a long time, as some of people's medicines were stored in their rooms, and some were kept in a locked trolley. The length of time taken to complete medicines rounds could cause people to have their medicines too close together or not adequately spread out across the day. We saw that one person who had been prescribed a course of antibiotics to be given three times a day, received all three daily doses within an eight hour time period, instead of having the doses spread as evenly as possible over the day. This meant that they may not have been as effective for this person. Staff were not ensuring they were observing people taking their medicines, but were signing the medicines administration

records (MARs) to say they had. Two people and one relative told us medicines were sometimes left on the side for people to take later. One relative told us when they visited they found the medicine had not always been taken. This meant people may not always get the medicines prescribed by their doctors.

The registered manager told us daily checks had been introduced since the last inspection to ensure staff signed MARs when all medicines had been given and none were left out in people's rooms. However, although MARs were filled in with very few gaps, there were four people where one or more doses of medicine had been signed as given, but we saw that the doses remained in the blister packs and had not been administered to those people. This meant that these people had not received their medicines in the way prescribed for them and the checks which were in place were not always effective.

One person had two entries on their MAR for the same medicine and dose. Both entries had been signed as the person having the medicine given each day, although staff told us they only gave the medicine once. One person was prescribed a medicine with a different dose on one day of each week; it was not clear on two occasions if the correct dose had been given. This meant the person may not have received their medicine as was intended by their doctor.

One person had been prescribed an antibiotic for a chest infection. The daily records for this person said this had made them unwell. We read in the same person's care notes, and staff confirmed, the person's doctor stopped the antibiotic after three days. The person's MAR for the period the antibiotic was prescribed did not record the antibiotic as being administered and taken by the person.

Other records to record medicines also included errors. Staff had signed the records on the date concerned and administered the medicine. The dose for one person's medicine had been written twice as administered to the person (on the same date and at the same time). Staff had not followed correct guidance on witnessing the giving of this medicine. When we reviewed the records and staff signatures, the registered manager did not know who had administered medicines as she did not recognise the signatures. Staff names and signatures enable an audit trail of administered medicines in the event of an error.

We found medicines were not managed properly or safely. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were given their medicines in a safe way during the medicine round we observed, and asked if they needed any medicines prescribed when required.

At the last inspection on 27 and 29 May 2015 we found there were no systems in place to take immediate action should an allegation of abuse be received. The registered manager sent us an action plan detailing the improvements they would make in this area. At the inspection the registered manager told us they had talked to every person in the home to check they felt safe. In addition staff had received or were booked onto safeguarding training. Weekly staff meetings discussed safeguarding and a flow chart had been developed so all staff knew how to report any incidents of concern. The registered manager was working closely with the local safeguarding team to improve their knowledge and understanding of this area and what should be reported to the local authority.

People confirmed they felt safe living at Higher Park Lodge. People felt comfortable speaking with staff and told us staff would address any concerns they had about their safety. Visitors also felt it was a safe place for their family member to live. Comments included "They don't harm me in any way"; "Definitely safe"; "I feel safe with staff, they keep me safe if other people are shouting or not in a good mood."

People were looked after by staff who understood how to identify abuse and what action to take if they had any concerns. Staff said they would listen to people or notice if people's physical presentation or emotions changed and that this might indicate something was wrong. Staff would pass on concerns to the senior member of care staff on duty or the registered manager. All staff felt action would be taken in respect of their concerns. Staff said they would take their concerns to external agencies, such as CQC, if they felt concerns were not being addressed.

Personal emergency evacuation plans (PEEPs) were in place and the provider had a contingency plan to ensure people were kept safe in the event of a fire or other emergency.

There were sufficient staff to meet people's needs safely during the inspection. The registered manager had systems which were flexible to ensure staffing levels were maintained at a safe level in line with people's needs. The registered manager told us they were always available in the event of staff shortage.

People and their relatives mostly told us there were enough staff. Three people told us there was not enough staff and gave examples of when they had to wait for care saying staff only had time to do the essentials. People told us if they used their call bell staff usually came within five minutes. Staff told us there were enough staff for them to meet people's needs safely although they did not have time to read people's care plans and would like more time to spend sitting and talking with people. We fed this back to the registered manager who agreed to consider these comments when assessing how many staff were needed to meet people's needs.

The home had safe recruitment processes in place. Required checks had been conducted prior to staff starting work at the home. For example, disclosure and barring service checks had been made to help ensure staff were safe to work with vulnerable adults.

Staff followed good infection control practices. We observed hand washing facilities and protective clothing such as gloves and aprons were available for staff around the service. Staff explained the importance of good infection control practices and how they applied this in their work.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found people's mental capacity was not always being assessed which meant care may not be given in line with people's wishes. We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had attended training in the MCA and felt this was helping them to understand their responsibilities under the MCA. Not all other staff had attended training but this was booked. The 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

However, people's records gave conflicting information about people's capacity and little guidance to staff on how to involve people in decision making where they did not have capacity. Records did not always demonstrate MCA assessments were taking place as required and the MCA was being followed. For example, people had treatment escalation plans (TEPs) in place. These are forms completed by medical personnel who state whether people are to be resuscitated or receive treatment at the end of their lives. We found some TEPs said people did not have capacity and were not to be resuscitated but staff told us these people did have capacity. This could mean some people were not given lifesaving treatment who might want it. The registered manger said she would review these forms, and consult with healthcare professionals, to ensure they contained correct information.

Staff told us they discussed people's care with a range of professionals and the family where appropriate to ensure any decisions were made in the person's best interest but this was not always recorded. Staff were not given clear guidance in the care plans on when they were acting in people's best interest, and staff did not always know who had the mental capacity to make their own decisions and who did not.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had not always applied for DoLS on behalf of all people who might require one. The registered manager had submitted two requests which were awaiting review by the local authority designated officer. One person had a DoLS in place but we had not been informed of this as required by law. Staff did not know who had a DoLS in place either which meant they may not be following the safeguards in place to protect them.

The legislative framework for the Mental Capacity Act (MCA) 2005 was not always being followed. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had a limited understanding of the MCA and DoLS however, we observed staff asking for people's verbal consent through their conversations with them and giving people simple choices to aid their decision

making. Choices were given to people for example in relation of what drink they had or what they might like to wear. Those people we spoke to told us staff always involved them in day to day decision making. One person told us "They know I like doing my own hair and my face. I want to keep some independence."

The registered manager advised us that new care plans which were in progress that would incorporate consent and DoLS information.

People's health needs or conditions were not always clearly recorded; advice sought was not recorded or the care plans updated as needed to give staff guidance. This meant staff may not have the latest information on how people should be cared for. A 'Health care professional visits' form for one person showed they had been seen once by a GP because of pain. Yet their daily care notes from three weeks before to our inspection on the 7 January 2016 did not reflect any such issue or the visit. One entry two weeks previously included "the pain has eased". Some, but not all, records detailed people saw their GP, specialist nurses, opticians and dentists.

Care records did not always reflect people's dietary needs. For example, one person was having their food and fluid intake monitored. There was no nutritional assessment or care plan in place for this person detailing the reason for this monitoring but their food and fluid chart said they had drank 750 mls on 15 January 2016 but no food was recorded, the 16 January 2016 was blank and the 17 January 2016 there was no record of food or drink being consumed until 4pm, so the record for this day showed they had only had 200mls fluid and a sandwich. The lack of accurate record keeping meant it was impossible to accurately know what the person was eating or drinking and whether this had been sufficient.

People's weights were not always taken regularly or recorded which meant those people losing weight were not always quickly identified and plans put in place to reduce further weight loss were sometimes delayed. When staff did identify weight loss however, people were referred to their GP. We found people's weights recorded inconsistently and in different places, for example one weight chart we looked at also had information on it about the person's baths. People's nutritional assessments were out of date and had not been regularly reviewed. One person's chart indicated their weight was falling but their nutritional assessment said they were not at risk.

Not maintaining accurate, complete and contemporaneous records of people's care is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people enjoying their lunch and being supported by staff where required. In addition to meal times and being offered drinks, people were encouraged to eat where and when they liked. People were provided with food and drinks when desired. People's likes and dislikes were sought by staff getting to know people. However, we found some staff did not know people's food preferences and one person told us staff didn't always remember they didn't like cheese, though staff told us the person had recently eaten cheese sandwiches. Care and kitchen staff however knew the person didn't like custard. Another person told us staff monitored their diet intake, adding that they wanted only small portions at mealtimes and staff remembered this. They told us they were offered "seconds", and weighed regularly. Another person also said "They always ask if you want any more." One person told us they enjoyed having lunch with their peers in the dining room but liked breakfast in their bedroom, which staff also respected.

People's care records included their dietary preferences and dislikes but when we asked staff about the people we had read about, they were not always sure about people's preferences. We asked one staff member about the person they were caring for, they were not sure what their preferences were and needed to ask the senior care member of care staff. Staff told us they did not have time to read people's care plans

so did not always know these personal details about people.

We found care was not always designed to meet people's needs or reflect their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People's special dietary needs were catered for, for example those who required a special diet for health reasons or those on a soft diet due to swallowing difficulties. People contributed ideas to the menu. We observed one staff member assisting someone with their lunch, they were patient and encouraging.

People spoke positively about the food "I've no complaints about the food, I eat whatever they give me"; "The food is very nice, they bring all sorts to me and it's so nice."

Staff did not always have the knowledge and skills to care for people effectively. For example, we checked three people's pressure mattress settings and found they were set incorrectly for people's weight. This meant the equipment they had to help reduce the risk of skin breakdown might not be effective. We spoke to the registered manager regarding the mattress settings and these were set correctly to people's weight during the inspection.

The registered manager was reviewing staff training for all staff to ensure staff were having the training they needed for their role. Staff told us they had received some training to carry out their role effectively and more was planned. The registered manager had organised training in the forthcoming months in areas she deemed essential to support staff to meet the needs of people living at Higher Park Lodge. These included training in skin care, fire training, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS); safeguarding adults, nutrition and hydration, food hygiene and medicine training. The staff we spoke with felt people's needs had changed over the course of time and this training would benefit them. Staff were also being supported to gain qualifications in health and social care.

People and their relatives told us they felt staff had the skills to care for them or their relatives well. One relative said, "They know the feelings of people and what they require" (explaining he meant staff knew his wife's mental and physical abilities and also her limits). He added staff understood "they are combined (a person's mental and physical state) – they can't get her to do things she doesn't want to do, such as physically get into a bath if mentally she doesn't want to." One relative was concerned staff did not have the skills to care for a person's particular continence needs but said they thought staff had sought support from the person's mental health nurse.

Staff told us they felt supported by the registered manager and staff had received supervision and appraisals. Additional informal support and supervision was offered for any staff that required it and any staff performance concerns were reviewed by the registered manager.

New staff underwent an induction when they started to work at the service. New staff shadowed other experienced staff. The progress was reviewed with new staff to offer any support and advice as required. The registered manager had introduced the Care Certificate to train all staff new to care to nationally agreed levels.

People told us their healthcare needs were met. One person said staff had noticed their leg was sore and swollen and had contacted their doctor quickly for them. Another told us they thought staff sought medical advice in a timely way when they were ill or feeling ill. They also thought staff followed advice given by healthcare professionals, such as from paramedics who attended after they fell. Records for this person showed they had felt unwell in the night and declined to get up the next day, so staff had requested a GP

visit, resulting in a review of their pain-relief. They had sought advice again (out of hours), two days later, when they were concerned about the person's complaints of pain and their appearance. However, one person told us their teeth were painful so they wanted to see a dentist. They told us they had spoken with staff "a long time ago" and staff told them they were organising this, though the registered manager told us she was not aware the person had a problem with their teeth. The registered manager told us she would follow up this person's request.

The new extension, new kitchen and enlarged dining area were decorated to a high standard. The registered manager had looked at dementia websites and chosen colours accepted as providing a peaceful and calm atmosphere. People living with dementia were supported to move around the service by the use of clear signs. There were not enough seating areas in the two lounges or dining area for the number of people who lived at Higher Park Lodge however, we saw the second lounge was empty and not used. The registered manager told us there were plans for a conservatory to be added to the ground floor lounge to increase seating; this was the area people liked to sit in most. We were told the two lounges and dining room were never full as many people enjoyed relaxing in their room, people confirmed this. The registered manager told us at Christmas everyone had been able to sit together for their Christmas meal including family who visited and shared the Christmas meal. We checked all the bedrooms after we found some people were not able to look out of their window or adjust the ventilation into their rooms, because the windows were too high for them to reach, or they looked on to a brick wall. The people, who were able to talk to us and share their views, told us this did not matter to them.

Requires Improvement

Is the service caring?

Our findings

At the previous inspection we found people's end of life care wishes were not always planned with them. We continued to have concerns people's end of life was not always planned with them in advance.

Details about people's end of life care and wishes were not always known by staff or well recorded. For example, one person had an "End of life decisions" form in their care records stating they wished to be cared for at the home. The same person had an undated care plan titled "Advanced decisions" stating the person had not yet made any decisions about the future, and that they did not have the mental capacity to make life-changing decisions. A further undated "Last preferences" care plan indicated the person was not to be resuscitated, they were unsure if they wanted to be transferred elsewhere if their health deteriorated, and had not said where they would want to live, despite the information on their "End of life decisions" record. Staff were not sure what they wanted. The lack of clarity about the person's end of life wishes meant they might not receive the care they wanted and needed.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us people's end of life wishes were to be incorporated into the new care plans being developed. One staff member was going to attend an end of life course and share this information with the staff team to improve care in this area.

Staff however felt people were supported at their end of life to maintain their dignity and be pain free.

People told us staff were kind to them "Staff are in and out like flies, that is not a complaint, they are looking after me very well"; "They're all kind and look after me very nicely" and, "The staff are all as good as gold." One relative told us, "Everything is done with love, care and attention. They're not saying, You've got to do this, or do that" and, "If she doesn't like something she tells them (staff), and they take it in and try to do their best for her." Another relative told us, "I'm much more content than I've been in a long time…he's put on weight…he's so much happier now he's being properly looked after. If he has a restless night, they get him up, give him a cup of tea and they always let us know about any changes straight away."

People told us staff protected their dignity at all times. For example, staff were discreet when delivering personal care and curtains were always drawn and doors shut. Following the last inspection locks had been put on most doors so people were able to lock their rooms if they wished. The staff we observed were gentle and engaged with people well, they noticed when they seemed cold and put a blanket over them and were patient as they supported them to move.

The atmosphere in the service was calm and people were observed to be happy in the company of staff. We observed the staff supported people throughout our time at the service with kindness, respect and in people's own time.

People were supported at times of needing emotional support from staff. For example, we read in people's care notes where staff had documented people had been upset so they had spent time with them talking.

Visitors were seen coming and going throughout our time at the service. They were always greeted warmly by staff and by name. They were updated on their family member's condition where appropriate and in private. Visitors confirmed they were always welcomed. Relatives said they observed staff were kind and patient when aiding people and saw they had a good rapport with people.

All the staff talked about the people they were looking after with a caring attitude. The registered manger felt totally confident people received good care.

People told us they were in control of every aspect of their care and staff mostly listened to them. One person told us they sometimes felt pressured by staff to sit in the lounge when they preferred their own company and their room. However, we saw from their care records staff had recorded when they had declined to go to the lounge and their wishes respected. People told us staff would take time to try and resolve any issues they had. People who were able to share their experiences with us, said staff would discuss options available and included them in the decision making process. People felt they were encouraged to remain as independent for as long as they possibly could and staff would make every effort to provide the necessary support or equipment required to maintain this.

Requires Improvement

Is the service responsive?

Our findings

People's care records lacked sufficient detail to enable staff to be responsive to their needs. For example, care records lacked guidance for staff on how to care for people's needs in relation to their skin, diet and weight, mobility and health related conditions such as diabetes. Care records also gave conflicting information. In one person's care plan for example, it was stated on one sheet they had no continence needs, another sheet stated they needed a bowel chart and used a commode, and their risk assessment identified them as medium risk of constipation, loose bowels and urinary infections but there was no care plan in place to direct staff on how to provide care in relation to these needs.

At the previous inspection, the recording of people's care was not always personalised or consistent across all records. We found little improvement in this area since the last inspection. People were not familiar with their care plans and it was not evident people or those supporting their care had been involved in developing or reviewing people's care plans. For example, one person's care plan included their hearing was good, but the person might sometimes choose to ignore people, with no further guidance for staff about how to communicate with the person. This person's care plan did not include the aspects they told us they were able and wanted to do for themselves in relation to their personal care. People were said to need support to bathe but not when or at what time of day they preferred to bathe. A staff member told us baths took place in the mornings. A section titled "Mental Health" in one care plan said the person's memory and cognition were not very good due to Alzheimer's, without guidance on how staff should therefore support the person. People's medical diagnoses or health problems were listed in care plans but without guidance or cross-reference to other parts of the care plan to guide staff on what to do as a result of having this knowledge.

Staff were unable to tell us how people preferred their care delivered. Staff told us they did not have time to read people's care plans. One staff member said they had read three of the 33 people's care records. Some people had information about their past lives, hobbies and background visibly displayed in their room. Some staff, who frequently went into these rooms, had not read this information so did not know people's past histories. This information can help staff have meaningful conversations with people and avoids people needing to repeat to staff their likes and dislikes and how they like care to be given.

Care plans and people's records were disorganised and not up to date, therefore did not record what care staff had given. For example, some people's records gave conflicting information about how often they should be checked or have their skin creamed. Other people's daily records had significant gaps so care given during these periods was unknown. For example, one person had a bowel chart in place but nothing had been recorded on this in the two weeks prior to the inspection. This meant they could be constipated. Assessments were not always clear or reviewed as people's health changed. For example one person had a "Mental Health Assessment" in their file which was completed in May 2012. This identified them as being "Very Heavy". Further notes indicated the person would "barricade themselves in their room and behaved bizarrely". There was no further guidance or direction in place for staff on how to support this person's needs.

We found there was no information in two people's records to indicate people had been given information and support to understand the choices available to them. For example two people were at risk of falls. Both had equipment such as alarm mats in place to reduce the risk of falls or notify staff if they fell. There was no evidence that their care had been designed with them to consider all their options , such as more frequent checks by staff or mobility aids. These discussions enable people to make informed decisions about their care and treatment preferences.

Care plans were not always developed collaboratively with people to meet their needs and reflect their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives said they were involved in discussions about people's care and they felt able to contribute their views.

Although how people wanted their care delivered was not clearly written in people's care plans, staff we spoke with knew, for example, how some people liked their creams applied. Daily care records for another person showed the person had stayed up later than usual one night, watching TV. The next day they asked to go back to bed for an hour and they were supported to do so. Staff generally knew people's preferences. For example, they told us this person liked "Her nails and make-up, and her clothes!" We saw this person was wearing nail polish and make-up.

Staff told us they participated in handovers which gave them current information about people's needs or they asked one of the senior staff if they were unsure.

People were provided with opportunities to remain cognitively, physically and socially stimulated. The activities co-ordinator had recently left but the staff member covering this role was supporting people to remain active. We observed nine people engaged in an activity and they all appeared to be enjoying the interaction. There were also regular trips out to places like the garden centre and the coast, these occurred more frequently when the weather was warmer. People told us they could join in or not as they wished. We saw people were enjoying their own hobbies such as needlework where able to pursue these.

People were able to use their personal computers and some people had mobile phones which they enjoyed using and enabled them to remain in contact with friends and family. However, there were long periods of people sitting in the lounge with the television on with no one watching the programme. The seating arrangement in the lounge meant the television was not visible to all who might want to watch a programme either.

People felt their concerns and complaints had been responded to and resolved to their satisfaction. People's concerns and complaints were acknowledged and investigated. People were not quite sure how to raise a complaint but told us they felt comfortable speaking to the registered manager and other staff. The service had a complaints policy in place. This was made available to people and relatives on enquiring about the service and there was a notice at the entrance to the home. The registered manager was available and talked to people about their care frequently enabling concerns to be picked up and resolved promptly.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found the provider did not have adequate systems to ensure the quality of the service. At this inspection we continued to have concerns about the effectiveness of quality monitoring of the service. Audits and checks which had been developed since the previous inspection were occurring but not identifying where there were problems. For example, the daily checklist for people's care interventions had not picked up incorrect mattress settings, food and fluid charts not being completed accurately and there were ongoing problems with care plans and record keeping.

The systems in place to monitor the quality of service people received were not effective. This is a breach of Regulation 17 of the Health and Social Care Act (2008) Regulations 2014.

At the last inspection we found not all significant events had been notified to the Care Quality Commission (CQC). The registered manager knew how to notify the Care Quality Commission (CQC) of any significant events which occurred in line with their legal obligations however we had not been notified of all injuries or people who had an approved Deprivation of Liberty Safeguards (DoLS) authorisation.

This is a breach of Regulation 18 (Registration) Regulations 2009 Notification of other incidents.

External agencies we spoke with felt they were not always kept informed of incidents and significant events as they occurred. The registered manager was open and transparent during the inspection but they had not implemented the required improvements from the last inspection in a timely way or kept to the timescale they had set themselves for completion.

The registered manager's audits for monitoring the cleanliness of the home and falls which occurred were being successfully implemented. The falls audit was recognising those who were falling frequently and this had prompted health professional referrals where indicated and a review of those people's care

The registered manager had systems in place to ensure the building and equipment was safely maintained. The utilities were checked regularly to ensure they were safe. Health and safety checks such as that for fire safety equipment took place regularly.

People and visitors spoke positively about the registered manager and felt comfortable approaching her. They felt any issues would be heard and acted on. People were involved in contributing ideas on how the service could be run. People and their families were asked to complete questionnaires but were also asked their opinion informally. People commented that their ideas were sought and put into action when we spoke with them.

Staff confirmed they were able to raise concerns and said these were dealt with properly by the registered manager. Staff had a good understanding of their roles and responsibilities and said they were well supported by the registered manager and deputy manager. Staff told us the registered manager worked alongside them. Staff said there was good communication within the staff team and they all worked well

together.

The registered manager took an active role within the running of the home and had good knowledge of the people and the staff. There were clear lines of responsibility and accountability within the management structure of the company. The registered manager demonstrated they knew the details of the care provided to the people which showed they had regular contact with the people who used the service and the staff.

The registered manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. We found the registered manager responsive to inspection feedback and keen to improve the quality of the service and care provided.

There was a whistleblowing policy in place to protect support staff and staff felt confident reporting concerns to the registered manager.

The local authority were working closely with the service at the time of the inspection and staff and the registered manager had found the advice and support helpful in starting to implement the required changes needed.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notification of other incidents Regulation 18 2 (a) 4(b) of the Care Quality Commission (Registration) Regulations 2009 The registered provider had not notified the Commission of a seious injury and an approved outcome of a deprivation of liberty safeguards application.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9(1)(3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care Care and treatment was not always appropriate, did not always meet people's needs or reflect their preferences. The registered person had not collaboratively, with the person, completed an assessment of needs and preferences or designed care or treatment with a view to achieving people's preferences and ensuring their needs were met.

The enforcement action we took:

warning notice repeated breach

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11(1) (2) (3) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent Care and treatment was not always provided with consent as the registered person was not acting in accordance with the MCA 2005 for people who were unable to consent because they lacked mental capacity to make particular decisions for themselves.

The enforcement action we took:

warning notice, repeated breach

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1) (2) (a) (b) (c) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2104. Safe Care and Treatment Care and treatment was not provided in a safe way for people including assessing the risks to the health and safety of people; doing all that was reasonably possible to mitigate risks; ensuring all staff providing treatment were competent and ensuring the proper and safe administration of medicines.

The enforcement action we took:

warning notice repeated breach

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) (2) (a) (c) and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance Systems and process were not always established to assess, monitor and improve the quality and safety of the service. Records of people's care were not always accurate, complete and contemporaneous.

The enforcement action we took:

warning notice repeated breach