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Highcroft Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was a second comprehensive inspection carried out on 23 and 24 March and was unannounced

Highcroft Manor accommodates and provides care, including nursing, for up to 30 older people mostly with dementia care needs. There were 23 people in residence on the first day of our visit and 22 on the second day because one person had been admitted to hospital.

The provider is a partnership; one of the partners is also the registered manager. The registered manager also managed another location. 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 registered manager had not fulfilled their requirements to the Commission as they had not provided notifications of all incidents or deaths that had occurred in the home.

There had been a systematic failure in all areas of assessment and monitoring of people's care resulting in risks to people's health and well-being. People did not always have their risks assessed or completed plans to mitigate their known risks. Staff did not always have access to plans of care that would provide instruction on how to provide care that met people's needs.

People received care from nursing staff that required more clinical supervision and training to meet people's needs. People were not sufficiently monitored for their health and nursing staff did not always act promptly on abnormal clinical observations. People could not be assured that they would receive all of their medicines as prescribed or their wounds managed appropriately.

People were not protected from potential harm as staff did not have strategies or plans to follow to protect people when people had behaviours that challenged others. Staff did not understand their responsibilities to report all incidents. Staff were not always kind; there was insufficient supervision of staff to ensure that they were supported to carry out their roles.

There were not always enough staff deployed to meet people's needs. People did not always have the ability to call for assistance and staff had little time to talk or support people with activities or socialising. Care was mainly task focused and did not take account of people's individual preferences and did not always respect their dignity. People were not always supported to have sufficient to eat and drink to maintain a balanced diet.

People were not protected from the risks associated with a poorly maintained environment. There was a failure to assess the environment for potential risks to health and safety or implement changes to protect people from potential risks.

People could not be assured that their verbal and written complaints would be addressed. There were no adequate systems in place to receive and act on complaints. People's records of care had not been maintained and all records in the home were disorganised.

We identified that the provider was in breach of nine of the Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3) and two Regulations of the Care Quality Commission (Registration) Regulations 2009 (Part 4). We took urgent action to impose a condition on the location's registration to prevent the service taking any new packages of care.

The overall rating for this service is 'Inadequate' and the service is therefore 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 complete our enforcement action of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

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.

People were not protected from potential harm as there were insufficient systems in place to ensure that staff understood their responsibilities to report all incidents.

People did not always receive care that met their needs as staff were not deployed adequately to provide their care.

People could not be assured that they would receive their medicines safely.

People could not be assured that they were cared for in a safe environment.

People did not always have their risks assessed or completed plans to mitigate their known risks.

People were assured that adequate recruitment procedures were in place to ensure that staff were suitable to provide their care.

Is the service effective?

Inadequate

The service was not effective.

People's healthcare needs were not always identified.

People received care from nursing staff that required more clinical supervision and training to meet people's healthcare needs.

People were not always supported to have sufficient to eat and drink to maintain a balanced diet.

People received care from staff that did not always have the supervision and support required to carry out their roles.

Care staff knew and acted upon their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Inadequate

The service was not caring.

People were not always supported to express their views and be actively involved in making decisions about their care, treatment and support.

Care was mainly task focused and did not take account of people's individual preferences and did not always respect their dignity.

Staff did not always support people with kindness and compassion.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive care that met their needs as staff did not always refer to people's care plans and not all care plans were reflective of people's needs.

People's needs were not always met as they did not always receive care that met all of their assessed needs.

People were not always involved in planning their care.

People did not have any meaningful activities, stimulation or social interaction with staff, other people using the service or the community.

People could not be assured that their verbal and written complaints would be addressed. There were no adequate systems in place to receive and act on complaints.

Is the service well-led?

Inadequate

The service was not well-led.

There was a registered manager who had not fulfilled their requirements to the Commission as they had not provided notifications of all incidents or deaths that had occurred in the home.

There was a systematic failure in all areas of assessment and monitoring of people's care resulting in risks to people's health

and well-being.

There was a failure to assess the environment for potential risks to health and safety or implement changes to protect people from potential risks.

People's records of care had not been maintained.

Highcroft Manor

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 23 and 24 March 2017 and was unannounced. The inspection was carried out by two inspectors from the Care Quality Commission.

Prior to this inspection we received concerns that the service did not always identify and take action when people's health needs deteriorated. We reviewed past inspection reports and statutory notifications sent to the Care Quality Commission (CQC) by the provider. Statutory notifications are information about important events at the service, such as safeguarding concerns, which the provider is required to send to us by law.

We also spoke with the local authority and clinical commissioning group, who have commissioning and monitoring roles with the service. We also contacted Healthwatch for their information about the service. Healthwatch is a consumer organisation that has statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

During the inspection we met all 23 of the people who lived at the service, we spoke with seven people about the care and support they received. Some people at the service were unable to engage in conversation with us about their care, due to the complexity of their needs. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with five relatives of four people, who were visiting over the two days of our inspection, to seek their views of the service. We spoke with eight care staff that included the registered manager, two nurses, four care staff and the chef. We reviewed the care records of nine people who were using the service and four staff recruitment files of staff that had been recently recruited at the service.

We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Inadequate

Is the service safe?

Our findings

People did not always receive their care as there were not always enough staff deployed to meet their needs.

Staff rotas demonstrated that staff were on fixed rotas, however, there was not a suitable system in place to cover shifts where staff had planned or unplanned absences. We observed that staff commenced their shifts at various different times of the day. The registered manager explained that most staff worked set shifts for when they were available and that's why staffing levels fluctuated each day. Staff were not allocated to provide care to meet people's needs, as the staffing rotas were set up for the convenience of staff.

Staff told us that the rota was not shared with them in advance so they didn't know who was on duty or who they would be working with. One member of staff commented, "I need to know who is working so we can plan the shift properly." Staffing varied every day, some days there were six care staff and on other days there were only two. Staff told us, "Some days are better than others." The provider later told us the rota was shared in the office and on-line.

People were not supervised in communal areas and staff were not always deployed to the communal areas. This left people at risk of incidents relating to people with challenging behaviour or falls when they mobilised without suitable assistance. We observed several people attempting to get out of their chairs when there were no staff present. Although we did not observe any falls, people were at risk of falls and injury. People told us they often had to wait for care. One person said, "Sometimes you have to wait a long time for the staff to help you." Another person commented, "Quite often in the mornings they [staff] are very rushed and don't have time to chat."

This was in breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

People were not always protected by the safe and consistent administration of their medicine. Staff did not have sufficient guidance for the administration of 'as needed' medicines. There were no protocols in place to state when medicines would need to be given or how to check that the administration of the medicine had been effective.

People were at risk of not receiving their medicines when they required as staff did not know when to give the medicine. For example one person had been prescribed three separate types of pain relief on an 'as needed' basis. We asked a nurse what the pain relief was for. They told us they didn't know they, "just asked if they wanted any." We saw that one of these was morphine and this, along with another pain relief medicine were prescribed in variable doses. When the pain relief had been given, staff had not recorded the times or the amounts administered. We brought this to the attention of the nurse who was not able to account for this. We were therefore not assured that people were given their medicines to meet their needs.

Staff did not always follow the provider's medicines policy or best practice guidelines which required two staff to sign handwritten prescriptions to state they were correct. We found there were numerous hand written entries on the Medication Administration Records (MAR) that had not been signed or dated by two staff members.

People were at risk of medicines errors as we observed that during a medicines round, the nurse was continually distracted by phone calls.

This was in breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People were not safeguarded from harm as there were not enough systems in place to recognise how and when people were harmed and these incidents were not always reported to the local safeguarding authority or the Care Quality Commission (CQC).

People were not always protected from the actions of other people using the service. We observed that people in the communal areas such as the lounge did not always have staff supervising them. Two people had behaviours that challenged others; we observed one person being verbally abusive and threatening to a small group of others sitting in the lounge, an incident then occurred where people could have been injured. We spoke with one person in the group who told us they did not feel safe when things like this happened. They commented, "I don't feel safe when [name of person using service] shouts and swears at us."

One person's relative described how they were in the lounge when another person who used the service frightened their relative; they told us, "There were no staff around, [name of person using service] caused her great distress." We discussed this with the registered manager who confirmed this incident occurred the evening before our inspection and they had raised a safeguarding alert. Not all the people living at the service felt safe. Two people told us they did not feel safe; one person explained that although they felt safe sometimes, staff would shout at them if they were very busy and in a rush. We informed the registered manager who told us they would investigate these allegations.

Although staff had received training to recognise abuse and were able to tell us how they would report incidents, we found not all incidents had been reported to the manager. People could not be assured that there were sufficient systems in place to protect them from abuse or improper treatment.

This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

People did not always have the facility to call for assistance when they needed and staff did not always respond appropriately.

People in the communal areas did not have access to a call bell to summon help when they needed. There was a call button in the lounge area, but this was out of reach of people sitting in their chairs. During the inspection the inspector activated the call bell in the lounge, due to an altercation between people who used the service. The inspector observed confusion as staff did not recognise that the call bell had been activated in the lounge.

People did not always have access to their call bell in their own rooms. We observed that five people who

could summon help could not reach their call bells as they were on the floor or out of reach. One person with a visual impairment told us, "My call bell was broken so they [staff] put string on it. I can't see it and I can't pull it and I can't manage it." We observed that the person could use a push button on their speaking clock, however, they had not been given a push button call bell; they were unable to summon staff assistance when they required it.

This was in breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

People did not always have their risks assessed in a timely way. Five people had been admitted to the home in the last three weeks. They did not have all of their risk assessments in place; two people did not have any care plans. One person had been in the home for a week and we saw that although they had a risk assessment for their skin integrity, the calculation of their risk was not accurate; the risk assessment did not indicate they were at high risk of acquiring a pressure ulcer which would require more regular repositioning, skin checks and continence care. The computerised care plans did not provide staff with clear instruction on how often they should provide the care to maintain their skin integrity and there were no paper care plans. This person had acquired moisture lesions to their skin within the week which were identified by the paramedics that attended the home during our inspection. The paramedics raised a safeguarding alert. Staff had not recognised that the person was at risk of acquiring sores and there were not sufficient systems in place or assess and mitigate the risks.

The provider had installed a computerised system for risk assessments and care plans. Although all care plans and risk assessments were in place for people living in the home before March 2017, during the month of March whilst the system for paper recording changed to computerised recording, staff did not always receive information about people's known risks or clear instructions on how to mitigate these risks. People who had been admitted to the home in March 2017 were at risk of falls, pressure ulcers and poor nutrition, staff were not always aware that these people were at risk. People could not be assured that they were receiving care that met their needs as the system to assess their risks was not in place.

Risk assessments were not always in place to provide staff with sufficient guidance to effectively manage people who had behaviours that challenged others. There was a lack of information about triggers for people's behaviours or control measures to minimise the potential for occurrence. There was no information about ways of managing people's behaviours to diffuse situations or de-escalate incidents. We observed that people's behaviours had a negative impact on others and at times put others at risk; staff did not have enough information about people's behaviours to know how to diffuse the incidents to keep people safe.

Most people had bed rails attached to their beds which were raised when they were in bed. One person had bed rails that were not protected by cushioning; there was a risk of entrapment in the bed rails.

This was in breach of Regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

People were not always protected from the risks of unclean, unsafe premises and equipment. During the inspection the carpeted floors in the corridors were being replaced by hard flooring. Although there had not been any reported accidents or incidents, there were no effective measures in place to protect people from the risks associated with renovation work had been carried out. There were building materials and

equipment stored in unoccupied rooms, the porch and the corridors which were accessible to people living at the service who were living with dementia. We observed that people mobilised through the corridors whilst the floors were being replaced; the floors were uneven and access had not been secured.

On the second day of our inspection the flooring in the entrance was being replaced; access to the home was via the large porch. We saw that building materials and old furniture was stored in the porch; a bed stored behind the door fell to the ground a couple of times and blocked the entrance and exit to the home. People were at risk of their exit being blocked in an event of an emergency. In addition we observed two fire doors of people's bedrooms that had been propped open, one with a bedside table and one with a heavy door stop. People were at risk of fire doors not closing in the event of a fire.

People had access to areas of the home that contained equipment that could potentially cause harm. The kitchen, store cupboard and the door to the garden were accessible to all. We observed that people who had dementia used the kitchen as a thoroughfare during the day, passing dangerous and hot equipment.

We observed that the fridge in the kitchen store contained food, the thermometer in the fridge indicated that the temperature of the fridge was 10 degrees, which is too warm to store food safely. We brought this to the attention of the kitchen staff who told us that the fridge had been left open by a person using the service. The registered manager told us the fridge was faulty and arranged for an engineer to fix the fridge. The garden contained old furniture which had been discarded. We brought the risks of people accessing these areas to the attention of the registered manager who immediately arranged for key pads to be placed on the doors to these areas. We observed on the second day that the kitchen was secure, but the door to the store and garden was kept open. People remained at risk of harm as they had access to areas that had potentially dangerous equipment and discarded furniture.

People were at risk of infections as the home was not clean. People's rooms, bedding and flooring were visibly dirty. We observed that beds had been made with dirty linen and equipment such as bed rail covers were visibly dirty. In bedrooms we found the walls were stained with drink spills and food debris. There was an unpleasant odour throughout the home and the laundry was full of heavily soiled bedding and clothes. On the second day of the inspection we noted that many waste bins in toilet and bathing areas were overflowing. We brought this to the attention of the registered manager who told us the usual housekeeping staff member was off and another member of staff had stepped in to do the house keeping that day but had only been available for four hours, they also told us of their on-going improvements to the flooring to aid their ability to clean the floors.

This was in breach of Regulation 15 (1) (a) (b)and (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

Staff had been recruited safely into the service. One staff member said, "Everything was checked before I could start working, references and my PIN number [nursing registration]." The registered manager told us that all staff employed by the service underwent a robust recruitment process before they started work.

Records confirmed that appropriate checks were undertaken before staff began work at the service. We saw criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history and character references, job descriptions, evidence of up to date registration with the Nursing and Midwifery Council and Home Office Indefinite Leave to Remain forms in staff files to show that staff were

suitable to work with vulnerable people.

Inadequate

Is the service effective?

Our findings

There was no system in place to monitor people's health and well-being following a fall, accident or incident. For example, records showed that one person had experienced a fall but had only one record of their clinical observations a couple of hours after the incident and not immediately after a fall; there were no clear records of their injuries or state of health. Staff had not made a reliable record of the fall and there was no system of follow up at regular periods to monitor their health and well-being. This person had complained of hip pain for over a week following the fall, and was eventually taken to hospital for investigation after staff raised their concerns with the GP.

People did not have their clinical observations taken on a regular basis or when they were admitted to the home. Healthcare professionals relied on the regular observations to compare when people became unwell. One person required medical attention during the inspection; they had not had any clinical observations since admission to the home a week before; paramedics did not have the information they needed to establish the change in the person's health. Where staff had carried out people's clinical observations, they were not always complete as staff did not always record people's respirations, pulse or temperature.

Some people required nursing care which included measuring how much fluid intake and output they achieved every day. None of the records of people's fluid intake and output were accurately recorded; staff told us and we observed that staff did not record these reliably. For example, one person's records showed they had drank between 10mls and 260mls of fluid a day and their output had not been monitored since they had been admitted to the home; they required urgent medical treatment relating to their fluids, as nursing staff had not detected that their fluid input and output were not balanced. Nursing staff did not monitor people's fluid balance and did not detect when people required medical intervention from the GP, which resulted in one person requiring urgent medical treatment.

There had been a period of three weeks in February 2017 where eight people had become seriously ill. Staff had followed protocols to inform the local healthcare professionals, however, during this time nursing staff had not always identified that people's observations indicated that people could have sepsis. Public Health England had been in touch with the service to advise them that one resident had a confirmed case of flu. A safeguarding investigation is on-going.

This was in breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People were at risk of not eating or drinking enough to maintain their health and well-being as not all people's nutritional assessments had been completed, and where they had, they had not been shared with staff. Five people had been admitted to the home in the previous three weeks. Information about their nutritional needs had not been fully completed and staff were not aware of their specific needs.

We were concerned to see that one person had lost 6% of their body weight in the first week they lived in the

home. The records showed that they had last been weighed on 3 March 2017; no action had been taken to refer them to the GP or dietitian and food charts had not been maintained to monitor how much they ate at every meal. They had not been weighed again. We also saw that three other people had lost between 5% and 19% of their body weight in the last two months; staff did not record what they had eaten or referred them to the GP or dietitian for medical assessment or nutritional advice. Their nutritional assessments or care plans did not reflect their current needs.

Staff were not adequately deployed to the dining room to ensure that people received their meals. We observed that some people had to wait for their meals because there were seven people who needed support to eat. We observed two people who did not eat their meals and another person in the dining area throwing their food onto the floor to feed the dog. Staff were not in the room and did not observe this. When staff took their plate away, it was nearly empty and appeared to have been eaten.

Staff reported how much people ate to the kitchen staff; however, the nurse and registered manager did not liaise closely enough with kitchen staff to identify when people were not eating their meals or when people's eating habits changed.

People did not have access to drinks when they wanted. We observed people in their own rooms without any drinks, or their drinks were out of reach and people in the lounge did not have access to drinks. We observed that drinks were provided with their meals and at set times, but the cups were cleared away promptly after these rounds. People were at risk of dehydration, and some were susceptible to urine infections and required regular and plenty of drinks. Staff did not record what people drank; there were no reliable records to indicate what people drank to ensure they could avoid the complications of dehydration.

This was in breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

People received care from staff that did not always have the support they required to carry out their roles. Nursing staff did not have adequate supervision or peer group support. The provider had not supported the nursing staff to develop their experience and practice as they had not provided support from other nurses employed by them. The nurses relied on external resources to facilitate their learning and development. This meant that there were areas of practice that required further development such as medicines management, management of wounds and care of unwell adults.

People received care from staff that were not always supervised. One person told us that sometimes staff would shout at them, they were distressed about this. We brought this to the attention of the registered manager and raised a safeguarding alert. Care staff told us they received supervision, but these were not carried out regularly. Records of staff supervision were not reliable as the registered manager who told us that up to date supervision records were not held in staff files anymore and they could not provide any further records. Staff relied on more experienced staff to provide their supervision, but their competencies had not been checked. We observed that staff were supporting each other.

People received care and support from staff that had completed an induction that orientated staff to the service. One member of staff old us "I had an induction when I first started work here and it was helpful because I had little experience in care." Records showed that staff received on-going training in areas such as moving and handling and food hygiene. Some staff had completed a vocational qualification such as a Qualification Credit Framework (QCF) in health and social care, newer members of staff completed the Care Certificate. (The care certificate is the new minimum standards that should be covered as part of the

induction training for new care workers).

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager and care staff were aware of, and understood their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS) and applied that knowledge appropriately.

Inadequate

Is the service caring?

Our findings

People's experience of living in the home varied. Some people had not established relationships with staff. One person told us "Some [staff] are better than others but overall it's okay really." One person told us that some of the staff shouted at them and was particularly anxious about one particular care staff. We brought this to the attention of the registered manager and we raised a safeguarding alert.

We observed some poor interactions where staff demonstrated impatience. For example one staff member was supporting a person with their lunchtime meal. The person grabbed the piece of fish from the plate and proceeded to eat it with their hands. The staff member commented, "Oh my god." and walked off. We also observed another person trying to eat mash potato with their hands. A staff member commented on this and then walked away. On both occasions staff did not attempt to encourage the person to use a spoon or fork to eat their meal or provide support to eat.

People were not always treated with respect and dignity. We observed one person in bed calling out; they were undressed and their skin was soiled. Another person had very long nails that were dirty, their hair was unkempt and their clothes were stained with food. We observed that people who had spilt food on their clothing did not always receive support to change their clothing in a timely manner.

This was in breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

We observed that staff interactions varied depending on the staff member, whereas some staff engaged people in conversation others barely spoke to people. We observed that staff were patient and kind when supporting people but their actions were largely task orientated rather than focussing on the person.. They provided support as and when required but social interaction with people was reserved primarily for when staff had to complete a task.

Some people had little or no contact with staff for long periods of time and we observed that they spent most of their day asleep or being passive observers in a room with little stimulation. On more than one occasion we saw that people had been left in dining chairs and wheelchairs for long periods, in positions that were likely to have compromised their comfort and mobility.

People were not always offered choices or were involved in decisions about their day to day routines. For example, throughout the day we saw that people were not always given choices about their drinks; at lunch time everyone was given blackcurrant juice with no alternative. We also observed one staff member who gave out some puddings to people. There was no verbal interaction with people or any choice offered to them.

One person had returned from hospital for care at the end of their life. They did not have an end of life care plan; staff did not have any information about the person's personal wishes or preferences. The hospital

discharge summary gave instructions to refer the person to the proactive care register, which is the register monitored by the community team for management of any end of life symptoms such as pain or breathlessness that may appear at end of life. Neither the staff nor the registered manager had made the referral as instructed; the person was at risk of experiencing symptoms without the skills and management of a specialist team to help manage them. During the course of the two days we observed this person and found they spent large periods of time alone.

This was in breach of Regulation 9 (1)(a)(b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-Centred care.

Where people had established long term relationships with staff we observed there were positive conversations between them. One of these people told us "The staff are nice. They help me a lot and make me laugh." A second person commented, "I like the girls. They are lovely and very caring."

Some staff we spoke with said they had worked at the service for a long time and they had built up positive relationships with people using the service. One staff member told us, "I love working here; it's a great job and we are like a family." A second member of staff commented, "It's a very good place to work; the manager is supportive of us and we work well as a team." We spoke with two staff who had worked at the service for a long time and who were very experienced. We found that both staff were compassionate and caring in their approach to people.

We observed that the kitchen staff made time to talk to every person about their meal choices and demonstrated they knew about people's likes and dislikes. They listened to people's feedback about their meals and used this to ensure that people received the meal as they preferred. People told us they enjoyed the food. One told us, "The food is nice, it's very good."

We did observe some good practices around maintaining people's privacy and dignity. Staff gave us examples' of how they maintained people's dignity and respected their wishes. One staff member said, "I always knock before entering people's rooms. I always cover people with a towel to stop them feeling embarrassed."

We observed staff knocking on doors before they entered and ensuring personal care was carried out in areas where people's privacy could be maintained.

Although staff felt they worked well together and were supported by the registered manager they had failed to see the impact their practice and lack of formal support had on the overall care of people.

Inadequate

Is the service responsive?

Our findings

People did not always receive care and treatment that met their needs. One person said, "It's alright here but I want to move now; they don't listen to me."

We observed that peoples' care did not always match what was recorded in their care plans. We found that decisions about people's routines were not always in line with their preferences and many people's daily routines were not person-centred but task led by the staff. People and their relatives had not always been involved in their care planning.

Five people had been admitted to the home in March 2017. They did not have care plans to mitigate all of their risks and they had not been consulted about their needs and preferences. The registered manager told us that these two admissions had been as an emergency to provide care for people who needed care at short notice.

One person who had been admitted in March 2017 with dressings to their legs; there were no care plans to provide instructions to staff to manage the dressings. The person required emergency medical treatment during the inspection; the paramedics found that the dressings that had been applied by the nurse were not in line with best practice. They removed the dressings to prevent further damage and they raised a safeguarding alert. The nurse had not sought medical advice for the wounds and the dressings were found to be inappropriate and had the potential to cause harm.

The registered manager was in the process of changing the care planning system from paper to computerised records; staff did not have access to all the information they needed to provide care. Not all of the risk assessments and care plans had been completed, where they had completed the care planning the information about people's fundamental care needs was basic and did not always reflect people's needs and preferences.

Staff could access the computer records via hand held devices; we saw the devices provided instructions that told staff to carry out specific tasks such as personal care and pressure area care at specific times. The instructions were completely task led.

We observed that staff were not using the hand held devices and did not follow the instructions generated by the computer. Staff did not record any of the care they provided. We observed that people did not receive the care they required to meet their needs. For example, people who required a regular change of their incontinence pads did not receive these in a timely way and people who required support with their meals did not receive the appropriate support.

People who had behaviours that challenged others did not have a clear plan of care to manage the impact of their behaviours on others or identify what triggered their behaviours. There was not enough guidance for staff to follow so they could provide a consistent approach. We observed incidents where people using the service were anxious about other people's behaviours, staff told us, "[Name of person using the service] can

be abusive to staff as well; we try to distract them to go to their room to calm down." We observed that staff did not distract the person and they remained seated in the lounge.

People did not have plans of care that met their specific needs. For example one person experienced pain and required medicines to help them to manage it. Staff did not have any written guidance and there was no plan of care to determine how staff were to administer the pain relief and monitor its effect. One nurse knew the person well; they told us "[Name of person using the service] cannot vocalise that she is in pain. I make my own judgement whether she needs the pain relief." There was a risk that the person would not get their pain relief, or get too much pain relief as staff would make individual judgements and not record their rationale for doing so, or record whether the pain relief had been effective

People's care plans did not provide enough information about people's care needs. For example, where people were at risk of pressure ulcers, an air flow mattress was placed on their bed to help relieve their pressure areas. The air flow mattress needs to be set at a level that corresponds to a person's body weight to be effective. The care plans did not provide staff with the required mattress settings for each person. We saw that three people were cared for on mattresses that were not set to their corresponding body weight and another person whose mattress had been set to 120Kg, with no rationale for the setting as they had never been weighed.

This was in breach of Regulation 9 (1) (a),(b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

Some people told us they were unhappy living at the home because they had little to occupy their time. One person told us "I'm not happy here. I don't get out. I want to go out but I can't on my own and no one takes me." We observed that people were left with little or no stimulation for long periods of the day. One person told us, "I do get bored."

Staff were not available to provide people with time to talk or carry out activities. Staff told us that activities for people did take place, however because of staffing constraints this could be difficult at times. One staff member said, "We do provide some activities. We do quizzes and dancing." Another member of staff told us, "It depends on the staffing levels what activities we can do. We do have some outside entertainers visit."

We observed an outside entertainer in the lounge area on the second day of our inspection. Although people responded well to this, there was a lack of staff presence to support people to engage them with the activity. A relative said, "I don't think there are enough staff to make sure everyone gets what they need." We observed that some people were still sat at the dining table from lunch time and had not been supported to move to join in.

People could not be confident that they knew how to make a complaint or that their complaints had been dealt with. People told us that they were bored and did not have enough activity. People experienced distress from other people's behaviours. Relatives told us there were not always enough staff to provide for people's needs. These had not been recognised by the registered manager as dissatisfaction of the service. People did not have access to the complaints procedure as no information of how to complain was made available to them.

The registered manager had some records of complaints from 2016; however they did not demonstrate how they had been dealt with or show how the service would improve as a result of the complaint. The complaints file was disorganised and contained information that was not relevant to a complaint. The

complaints file contained one complaint from 2017. The registered manager had not recorded or responded to verbal complaints that had been made by people who used the service, or their relatives.

This was in breach of Regulation 16 (1) and(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

The provider was a partnership; one of the partners was also the registered manager. The registered manager also managed another location.

The registered manager understood their responsibility to notify the commission of deaths of people who used the service. We received notifications for some deaths, but we found evidence of people who had lived at the home and had died, where we had not received a notification.

This is a breach of Regulation 16 (1)(a) and (b) of the Care Quality Commission (registration) Regulations 2009 (Part 4) Notification of death of service user.

The registered manager had also failed to notify the CQC of incidents. We had received notices for some incidents. However, we observed an incident where people had been subject to abuse from other people using the service. The registered manager had not submitted notifications regarding all incidents. We could not be confident that the registered manager had reported all other incidents as their records were disorganised and the registered manager did not appear to recognise their responsibilities.

This is a breach of Regulation 18 (5)(b)(i) and (iv) of the Care Quality Commission (registration) Regulations 2009 (Part 4) Notification of other incidents.

The provider and the registered manager failed to ensure that all people's needs had been assessed and monitored and had failed to mitigate all the risks related to people's health, safety and welfare. There were no systems in place to assess monitor and improve the quality and safety of service users. There had been a systematic failure of all the systems that had been in place at the service.

The registered manager was not at the service full time; the provider's staffing levels report showed that the manager provided only 25 hours a week to the service. The manager told us and their registration demonstrated that the registered manager also managed another service. We highlighted our findings to the registered manager during the inspection and expressed our concern that there was no full time manager, or any other staff with managerial experience in the home. We were concerned that there was not enough managerial oversight of the care provided at the service.

The provider had not ensured that the nursing staff had adequate clinical supervision. This had left nurses with not enough guidance or resource to ensure they were providing care that reflected best practice. This had led to poor medicines management and at least one person with inappropriate wound care. People were not adequately monitored for their health and well-being following an accident and nursing staff did not monitor people's clinical observations regularly; this had resulted in paramedics not having enough information about a person when they attended in an emergency.

The provider did not have an adequate system to protect people from the risk of infection. An audit carried out by the provider in February 2017 identified that seven people had become unwell in a three week period in February 2017; they identified that hand hygiene training was required for staff. We saw that this had not been carried out. There was no system in place to ensure that staff washed their hands before and after they provided care. We observed that not all sinks had soap or hand gel available for staff to use to wash their hands. The registered manager did not ensure that staff wore uniforms which were able to be laundered at a high temperature to help prevent the spread to infections. We observed staff not using protective aprons or gloves when providing personal care. People were at risk of acquiring infections as there were no suitable systems in place to ensure that staff complied with infection control measures.

The registered manager had not ensured that people who had been admitted to the service in March 2017 had been assessed for all of their needs before admission, or since their admission. They had not ensured that people who had returned to the home from hospital received the prescribed care they needed. There was inadequate supervision of staff to ensure they understood people's needs. This had led to people not receiving timely personal care or pressure area care, resulting in at least one person acquiring skin damage.

The provider failed to put into place any system that ensured people continued to receive their planned care during the change of care records from paper to computer. The provider also failed to ensure that staff understood the instructions generated by the computer and record the care they gave. The registered manager told us that during March 2017 they had advised staff not to record any care as all the care records were being changed. This had resulted in staff not providing people's care in line with their needs as they could not establish when care was due because there were no records.

People did not have access to staff when they required it as call bells were not always within reach, or not available in communal areas. The registered manager had not deployed enough staff to meet people's needs or provide cover for planned and unplanned absences. One member of staff told us, "Some staff call in sick right at the last minute. It makes it very difficult to find another member of staff at short notice so we often work shorthanded. I don't feel that this is ever addressed." Staff rotas were created for the convenience of staff availability which meant that at times, especially at weekends there were not enough staff to meet all of people's needs.

The registered manager did not monitor how staff provided the care and we found that people experienced negative behaviour from some staff. This behaviour had not been identified by the registered manager or reported by other staff. The registered manager had not ensured that staff understood their responsibility to safeguard people from potential risks of harm, or how to report these.

People experienced fear and anxiety due to other people's behaviours. The lack of adequate risk assessments and care planning contributed to staff not knowing how to manage people's challenging behaviour or how to protect people from this. The registered manager did not always report these incidents to the safeguarding team or the CQC.

The provider did not have systems in place to monitor the quality of the care provided. People were not closely monitored for their risks of poor nutrition and hydration; people had lost weight in a short period of time and there were no systems in place to ensure people were referred to the GP and dietitian in a timely way.

The provider had not assessed the environmental risk to people during the refurbishment of the home. People were at risk of accidents and injury as they had access to areas where building materials and equipment were stored. People were at risk of accidents as they had access to the kitchens; the provider

failed to recognise that having free access to the kitchens was a risk.

The provider did not ensure that there were adequate systems in place to ensure the cleanliness of the home. People were at risk of infection from contamination from dirty laundry, carpets, bedding and clothes. There was no system in place to monitor and assess the effectiveness of the cleaning of the service. In an audit dated January 2017 we saw there was an outstanding action: 'supervision of cleaning' which had not been implemented. The due date was the 30 September 2016.

There was no system in place to monitor the safety of equipment. People were cared for on air mattresses that were not set to the correct settings, leaving people at risk of not receiving adequate pressure area care. The air mattresses were controlled by electrical pumps; some of which did not have an up to date Portable Appliance Testing (PAT) sticker. These are placed onto the electrical appliances to demonstrate that it has been tested by a qualified person for their safe use in a care home. We saw five people's mattress pumps which had not been checked since 2014 and two further mattress pumps had no PAT stickers on them. There was a risk that people were being cared for on mattresses which had not been checked for their safety.

This was in breach of Regulation 17 (1 and 2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure that the care and treatment that service users received met their needs, was appropriate and reflected their preferences.

The enforcement action we took:

We imposed a condition to prevent any new admissions or re-admissions to the service without the permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure that service users were treated with dignity and respect at all times.

The enforcement action we took:

We imposed a condition to prevent any new admissions or re-admissions to the service without the permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure that: * The risks to all services users health and safety had been assessed and put in place risk management systems in lace to mitigate any such risks. * Persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. * Practices for the safe management of medicines had been consistently followed * The risk of, and preventing, detecting and controlling the spread of, infections,including those that are health care associated had been

assessed and safely managed.

The enforcement action we took:

We imposed a condition to prevent any new admissions or re-admissions to the service without the permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to ensure systems and processes were in place to protect service users from abuse and improper treatment.

The enforcement action we took:

We imposed a condition to prevent any new admissions or re-admissions to the service without the permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider had failed to ensure that the nutritional and hydration needs of service users were met.

The enforcement action we took:

We imposed a condition to prevent any new admissions or re-admissions to the service without the permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to ensure that the premises and equipment used by the service provider were clean, secure, suitable for the purpose for which they are being used, properly used and maintained. The registered provider had also failed to maintain standards of hygiene appropriate for the purposes for which they are being used.

The enforcement action we took:

We imposed a condition to prevent any new admissions or re-admissions to the service without the permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

Diagnostic and screening procedures Treatment of disease, disorder or injury	The registered provide had failed to ensure that they had sufficient systems in place to identify, receive, record, handle and respond to complaints.

The enforcement action we took:

We imposed a condition to prevent any new admissions or re-admissions to the service without the permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to: * Assess, monitor and improve the quality and safety of the service and the risks relating to the health, safety and welfare of service users and others who may be at risk. * Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. * Attain feedback from relevant persons and other persons routinely for the purposes of continually evaluating and improving such services.

The enforcement action we took:

We imposed a condition to prevent any new admissions or re-admissions to the service without the permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure that there were sufficient staff deployed to meet people's needs.

The enforcement action we took:

We imposed a condition to prevent any new admissions or re-admissions to the service without the permission of CQC.