Mr David Moseley & Mrs Barbara Selina Moseley

Highbury House Care Home

Inspection report

580-582 Lytham Road
Blackpool, Lancashire
FY4 1RB
Tel: 01253 344401

Date of inspection visit: 21, 23 & 30 October 2015
Date of publication: 07/03/2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 21 & 23 October 2015 with feedback on 30 October 2015 and was an unannounced inspection. The service was last inspected in August 2014. They met the requirements of the regulations that were inspected at that time.

Highbury House is located in South Shore, Blackpool. The home is registered to accommodate up to 28 people who require assistance with personal care. The property is a large detached house with accommodation over two floors. There is a passenger lift for ease of access and the home is wheelchair accessible. The majority of the bedrooms are single occupancy and en-suite. There are private parking facilities at the front of the building and garden areas at the rear. During this inspection there were 28 people living at Highbury House.

There was a registered manager in place. 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.

Through our observation and discussions with people we noted that a number of systems to keep people safe had

Summary of findings

failed. There were numerous breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which meant the service was not safe, effective, caring, responsive or well-led. You can see what action we told the provider to take at the back of the full version of the report.

People told us they felt safe living at the home but people were not protected from risks of harm. Although risk assessments were in place about nutrition, falls and pressure area care, they were not in place for risks related to excessively hot water, a person leaving the home unescorted or a person drinking alcohol to excess. Actions to manage risk were not identified to guide and support staff in keeping people safe.

Staff did not manage behaviours that challenged the service appropriately to keep people safe. We were told physical intervention was being used with one person but this had not been agreed or authorised.

We had significant concerns about people's environmental safety. These included excessively hot water, first floor windows without restrictors, the gas certificate was out of date and legionella checks were not carried out. The registered provider made sure the water temperatures were reduced and window restrictors replaced within 48 hours so people were not at immediate or significant risk.

Staff did not follow the code of practice in relation to healthcare associated infection. Infection control was poor, with an unpleasant odour in the home during the inspection and unclean and unhygienic equipment in a bathroom and bedroom. This was rectified after the inspection.

We saw medicines were managed safely. They were ordered appropriately, checked on receipt into the home, given as prescribed and stored and disposed of correctly.

Staff recruitment was unsafe and the necessary checks were not made before staff started working in the home.

Staffing levels were unsafe and put people at risk. People who had high care needs were left unsupervised, with little stimulation or attention for long periods of time. We also saw two people living with dementia had left the home unaccompanied and unnoticed. The registered provider told us following the inspection that an additional member of staff was being recruited for the evening shift.

Staff failed to work within the Mental Capacity Act. We observed people were deprived of their liberty without authorisation. There was no documentation that best interests, consent, risk assessment and mental capacity assessments had been undertaken in relation to deprivation of liberty. Staff we spoke with did not have sufficient knowledge in this area.

Care files sampled showed no evidence people or their relatives were involved in planning and updating care. Consent to care was not recorded.

We observed poor care practices around supporting people to take drinks, with moving and handling of people and with supporting people with behaviour that challenged. However we also saw pockets of good practice with staff talking quietly with people and encouraging them in tasks.

Care was not person centred and choices of when to receive personal care and support were limited by the staff routines. We saw there were few social and leisure activities in place and no meaningful activity aimed at people living with dementia. People's privacy and dignity was usually but not always maintained.

The management team had started developing the environment to assist in supporting people living with dementia. We saw measures to improve well-being and independence for people with dementia were in place.

Care records were not always fully completed, accurate or up to date. Some sections of care records were in-depth and individualised to the person's needs, whilst other sections lacked detail or were inaccurate and out of date. Some information in relation to care needed and incidents that had occurred was missing.

The home had a complaints procedure which was made available to people they supported and their relatives. There was mixed views about how concerns were handled. Eight people we spoke with who lived at the home said they had no complaints about the home. However one person was not happy with how concerns were handled.

Summary of findings

The registered manager told us the views of people who lived in the home were sought. There were formal systems in place for people's views to be sought but there were no residents meetings when we inspected. Surveys about the person's experience of living in the home had not been sought within the previous two years. This lessened the opportunity for people to voice their opinions. The registered persons sought people's views towards the end of the inspection.

The registered person's did not fulfil their responsibilities. They did not ensure people's care and the environment were safe and meeting people's needs. The registered manager had not informed the Care Quality Commission (CQC) about incidents as they were required to.

Although there were systems in place to assess and monitor the quality and safety of the services provided, these were not operated effectively.

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures

Summary of findings

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.

Although people told us they felt safe staff did not consistently provide safe and appropriate care to people. Procedures in place to protect people from the risk of abuse had not followed.

Staffing levels were not sufficient to provide safe care. People who had high care needs, were left with little stimulation or attention for long periods of time.

Infection control practices did not ensure cleanliness or reduce the risk of cross contamination.

Is the service effective?

Inadequate

The service was not effective.

The Mental Capacity Act 2005 (MCA) had not been followed to enable staff to assess peoples' mental capacity, should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk. Staff did not have a working knowledge of the MCA.

Staff were not trained effectively to support people with behaviour that challenged the service and they did not have sufficient skills and knowledge about safeguarding vulnerable adults and the Mental Capacity Act.

People were offered a choice of nutritious meals. The people we spoke with told us they enjoyed their meals.

Is the service caring?

Requires improvement

The service was not always caring.

Some people were not provided with appropriate care and attention. People were left unsupervised and unsupported at times.

We observed poor care practices from some staff when they supported people.

Most staff spoke with people in a respectful way and respected people's privacy and dignity.

Is the service responsive?

Requires improvement

The service was not always responsive.

Information within care plans was not always in place or did not adequately guide staff to assist them to respond to people's needs.

Our observations showed that staff provided care in a task centred way rather than in response to people's individual needs and preferences.

Summary of findings

People were aware of how to complain if they needed to. Most people said any comments or complaints were listened to.

Is the service well-led?

Inadequate

The service was not well led.

The registered persons did not ensure that care was safe and person centred or that sufficient staff were deployed.

Through our observations and discussions with people, we noted that a number of systems to monitor the quality of the service and keep people safe had failed.

There were formal systems in place for people's views to be sought. However these had not been completed within the previous two years until towards the end of the inspection.

Highbury House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 21, 23 & 30 October 2015 and the first day was unannounced. The inspection team consisted of three adult social care inspectors and an inspection manager.

Before our inspection we reviewed the information we held on the service. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who lived at the home. We also checked to see if any information concerning the care and welfare of people who lived at the home had been received.

We spoke to the commissioning department at the local authority and contacted Healthwatch Blackpool prior to our inspection. Healthwatch Blackpool is an independent consumer champion for health and social care. This helped us to gain a balanced overview of what people experienced whilst living at the home.

During our inspection we spoke with a range of people about the service. They included the registered manager, the registered provider, four members of staff on duty, nine people who lived at the home, five relatives and four health and social care professionals. We spent time observing the care and support being delivered throughout the communal areas of the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care and medicine records of three people. We also looked at the previous three weeks of staff rota's, recruitment records for two staff, the training matrix for all staff, and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

People who lived at the home and relatives spoken with had mixed views on whether they thought people were safe at Highbury House. One person said they were safe and well looked after. Another person told us, "I know the staff are there if I need them. It makes me feel secure."

Several relatives told us that they were satisfied with care in the home and their family member was safe. However this did not reflect our findings. Five people who lived at Highbury House and their relatives told us the behaviour of another person who lived in the home frightened them. They said the person often went into people's rooms and would not leave them. When requested to go they tried to scratch or hit out at people. Staff were aware the person was frightening others by their behaviour. One member of staff said, "We know it is a problem. We do try and stop it happening.

Care plans seen had risk assessments in place about falls, nutrition and pressure area care. These provided instructions for staff members when delivering their support. However risk assessments were not in place for specific risks such as hot water, behaviour that challenged, a person leaving the home unescorted or a person drinking alcohol to excess. This left staff without guidance on supporting people safely.

We looked at care records of a person who we were informed had behaviours that challenged the service. Although there was information about the person's behaviour the only guidance about how to manage the behaviour was a sentence saying 'If the person says No never try to rush them'. There was no information about how to distract the person or divert their attention to defuse a situation or how to support the person when distressed.

We also observed staff interactions as to whether these would improve the wellbeing of one person. There was little interaction with the person and they were left in their bedroom for long periods of time without attention or supervision. When the person came out of their bedroom we saw that staff attempted to guide them back to their room. We observed the person in a distressed state and shouting. We saw a newer member of staff trying to lead the person back to their bedroom, although they did not want to go. The person was scratching and nipping staff and screaming and the member of staff was unable to move them. After several minutes the registered manager intervened and walked the person to a quiet area of the home. When they walked back the person was still distressed although they then went back to the bedroom. We spoke with the registered manager and asked for any additional guidance. She told us there was no other information and said, "Most staff have done a challenging behaviour course."

We were told by staff and a relative that one person living with dementia had left the home unaccompanied and unnoticed a number of times. We saw from care records there were two occasions where the person had left the home recently. We saw an entry in the care records referring to this 'happening too often'. We looked at the person's care records. There was no risk assessment relating to leaving the home and no information suggesting that this could or did occur.

We asked the registered manager how many people at risk if alone outside, had left or tried to leave the home unnoticed. The manager had told us, this was the only person. However we were told another person had left the home unnoticed shortly before the inspection. We saw a brief report of this in the daily records. It stated that the person had been found by paramedics in the 'back alley, having fallen there. We looked at the person's care records. There was no risk assessment relating to leaving the home and no information suggesting that this could or did occur. The care plan had not been updated to reflect this incident and there was no guidance to assist staff in providing safe care.

The staff we spoke with said they would have no hesitation in reporting abuse. They were able to describe the action they would take if they became aware of abuse. They told us they would contact the manager or another member of the management team. They added they would contact the local authority if a senior manager was not available. However staff did not show understanding that poor care practice, unauthorised physical intervention and depriving people of their liberty was abuse.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to assess the risks to people of receiving poor care and to ensure processes were in place to manage and minimise those risks.

Inadequate

Is the service safe?

There had been a safeguarding alert made to the local authority earlier in 2015. This related to staff attitudes and social media. This had been substantiated. The registered manager had not informed Care quality Commission (CQC) of the safeguarding issue as is required.

This is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009 because the provider had failed to Notify CQC of a safeguarding concern.

We saw staff had received basic challenging behaviour training in April 2015. New staff had not yet received this. We spoke with and observed staff supporting one person. Staff told us this person had hurt other people through kicking and scratching. Care records showed that the person could react negatively to interventions. We asked staff how they managed the person's behaviour. One member of staff told us, "We talk to them and be happy with them. If you're stressed they'll be stressed. You need to be calm and placid and have a laugh and a joke." Another member of staff said, "We just walk [the person] round the home until [they] fall asleep." When they scratch or grab us we use a suitcase hold to get them to release their grip." The member of staff demonstrated this physical intervention on themselves.

Staff did not pro-actively support the person so that the likelihood of behaviour that challenged was reduced or use techniques to de-escalate specific behaviours. Rather, during the inspection they rarely interacted with the person unless reacting to incidents when they occurred. One member of staff talked about using a 'suitcase hold' as part of physical intervention.

We looked at this person's care records. We found there were significant risks to people because care practices did not protect people from abuse and unsafe care. We saw there were no risk assessments, care plans or management strategies in place to support the person. Neither were there records of what the physical intervention entailed, whether it had been agreed as in the person's best interests and authorised to use or under what circumstances to use this.

The registered manager told us staff had received training, in behaviour that challenged. She showed us training certificates for staff. However she said she did a different training course so did not have the information about the content of the training the staff had completed. She told us she felt staff were caring for people who challenged correctly as she watched them support people. However as she did not know what they had been taught and there was no guidance it would be difficult to ensure consistency.

These are breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to operate effective systems to protect people from abuse.

When we looked around the building we saw staff did not always ensure people's safety. We checked the water temperatures to see if they were delivering water at a safe temperature in line with health and safety guidelines. We found the hot water in en-suite baths was so hot it was not possible to keep a hand under the flow. Although there were small signs to advise people about the hot water, there were no risk assessments in place to assess and reduce risk to individuals. This put people at risk of scalding, particularly where they were not sensitive to temperature or were living with dementia. We spoke with the registered manager and provider about our concerns. The registered provider told us that there was no system in place to check the water temperatures as they had thought it was enough to have thermostatic valves in place.

Two first floor rooms had inadequate window restrictors on them, so opened to their fullest extent, allowing exit from these. Window restrictors are fitted to limit window openings in order to protect vulnerable people from falling. There was no assessment in place to assess the risk and no system in place to routinely check window restrictors were in place and functional.

The registered provider made sure the water temperatures were reduced, window restrictors replaced within 48 hours. This ensured people were not at immediate or significant risk. However systems had not been in place to assess the risks to people and to manage and minimise those risks.

We saw unsafe moving and handling techniques. We observed staff moving people in wheelchairs to and from the dining room. We saw three people being moved in their wheelchairs. Footrests on the wheelchairs had not been used by staff and we observed peoples feet dragging on the floor as they pushed or pulled the wheelchairs along.

We saw a member of staff pushing a person in a wheelchair, with the person's feet were being pushed along the floor. The member of staff said "pick your feet up" to the person several times, as they travelled from lounge to

Is the service safe?

dining room. We also saw staff pulling wheelchairs backwards, with people in without footrests. Lack of proper foot support may increase pressure behind the knees. Feet are also at risk of incurring a fracture against furniture and doorways. These incidences were reported to the registered manager on the day of the inspection. When we spoke with the registered manager about the poor moving and handling, she accepted pushing the wheelchair forwards with no footrests was unsafe.

These are breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to assess the risks to people of receiving care and to ensure processes were in place to manage and minimise those risks.

We looked at how Highbury House was being staffed. We did this to see if there were enough staff on duty to support people throughout the day and night. We asked people who lived at the home, relatives and staff if there were enough staff on duty to provide care and support.

There was a mix of views with two people who lived in the home and three relatives felt there were enough staff available. However other people felt there were not always enough staff available to assist people, particularly those who were dependent. Five people told us that there were rarely any activities because staff were too busy. Three people told us staff were kind but busy. One person said, "Staff are always willing to help. There are enough staff for me. I don't need a lot." Another person told us, "The care staff are kind, but oh so busy. They are always rushing about."

We observed that during the inspection staff went about their duties in a hurried way with little time to interact with people. We saw staff unable to support people when they required assistance as they were supporting other people or carrying out other tasks. On one occasion before lunch time we saw people living with dementia left unattended or with minimal supervision for a period of 35 minutes. This left them at risk of harm as they were unable to contact staff. They were also unsupported to drink the drink they had been given. Without assistance or encouragement to drink, six people left this to go cold.

Two staff said there were insufficient staff in an evening and that they were busy or 'stretched' in the evening. One member of staff said, "We are always running round trying to get things done." When we asked about deployment of staff, they said that there were periods in the evening where people were left unattended in the lounges. This was particularly when a person needed the support of two staff for personal care or getting to bed. This staffing left people unsupported or unsupervised for periods of time. Where people were living with dementia it would be expected that a member of staff was in the vicinity of communal areas at all times. Staff not being available to regularly check the well-being of people put people at risk of harm.

We looked at staff rotas and found there were only two members of staff on each shift from 5pm until the following morning. We saw from the 'staff routines' information that evening staff were expected to carry out cleaning duties as well as caring for people. There were 28 people who lived at the home when we inspected. We were told by staff at least 15 people were living with dementia and almost everyone needed assistance with personal care. We saw brief information on people's health and care needs which reflected this.

We saw in care records that two people living with dementia, had recently left the home, unnoticed by staff. On one occasion staff did not realise one person had gone until they were informed the person had been found in the area by the police. The person was taken to their family home and staff informed. One member of staff said, "They were checked regularly but somehow got out through the fire exit. It was a blur really. I was that busy. Someone came and told us that [they were] out."

We asked the registered manager about staffing and how she reviewed staffing levels to make sure they met people's needs and dependency levels. She said she didn't review staffing against dependency levels and the staffing 'was as it was'.

This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider has failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and failed to review staffing levels and skill mix and respond to the changing needs and circumstances of people using the service.

Staff recruitment and selection processes were unsafe. There was a recruitment procedure in place but this was not being followed. We looked at the records of two

recently appointed staff. They had both completed an application form. However they did not give a full employment history or their reasons for leaving previous employment. Where they gave employment details, they gave only the year of moving jobs. There were no evidence in the recruitment records to demonstrate gaps and discrepancies in people's employment history on the applications had been followed up. We spoke with the registered manager who told us any conversations to explore gaps was not recorded.

The recruitment procedure stated there must be two satisfactory written references and a disclosure check prior to the member of staff commencing in post. It further stated verbal references could be sought in addition to the written references. Contrary to the procedure, the registered manager had not sought written references. She showed us a record of verbal references she had received for each applicant. However these had little information about the applicants work ability. They did not show the name of the person the registered manager had spoken with, one reference stated 'Manager for the day'. The other references did not show their role in the organisation, so it was difficult to evidence who had provided the reference.

We looked to see if the new staff had completed Disclosure and Barring Service checks (DBS) (formerly CRB checks) before starting work. These checks were introduced to stop people who have been barred from working with vulnerable adults being able to work in such positions. The staff files we looked at showed us staff had not had a DBS Adult First Check before they were allowed to work in the home. This is the initial check made by an employer to make sure a person is safe to start work with vulnerable adults, under supervision, before a DBS certificate has been obtained. Neither had they had a full DBS check and therefore were working with vulnerable people without having the necessary checks.

This is a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider has failed to operate safe and effective recruitment procedures to ensure that persons employed are of good character.

We saw people were not being protected against identifiable risks of acquiring an infection. One person was waiting to be transferred to the local hospital as their health had deteriorated. We saw there was faeces on their personal care equipment (catheter bag) and on the bed. The ambulance personnel had arrived to take them to hospital. This had not been cleaned before they left the home and left them in an unclean and undignified state.

There was an unpleasant odour of urine throughout the home on the inspection and infection control practices were poor. The walls and furniture in one bedroom were stained with bodily fluids and unhygienic and unpleasant to be in. An en-suite bathroom had a rusty and flaking toilet aid around the toilet. A bath aid in one bathroom was damaged, stained and had ingrained dirt throughout. These were unsafe and risked people developing an infection or injury.

Staff wore personal protective clothing when involved in personal care and at mealtimes, which assisted with reducing cross infection. When we observed lunch we did not see staff encouraging or supporting people, where required, to wash their hands or on two occasions after using the toilet. This increased the risk of cross infection.

We found infection control record-keeping regarding cleaning was poor and monitoring of cleanliness around the home infrequent and inadequate. The audit was not fit for purpose. It had been completed twice in twelve months and had not found any issues of concern. Once was three weeks before the inspection. The poor cleanliness we saw had built up over significantly longer than three weeks.

We spoke with the registered manager about our concerns. The registered manager and staff team did not follow the Healthcare Associated Infection Code of Practice. These are standards services are required to meet under the Health and Social Care Act 2008.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to effectively assess, monitor, manage and maintain infection control. The provider had failed to ensure staff were guided about and followed the Code of Practice in relation to Healthcare Associated Infection.

When we returned to discuss our findings, the home smelt clean and fresh and equipment had been cleaned or replaced. The bedroom stained with bodily fluids had been cleaned and redecorated. The registered manager

Inadequate

Is the service safe?

provided us with a copy of a completed survey which had been completed since the first two days of inspection. A relative said through the recent survey, "It's clean, tidy and very secure. It is very homely."

We looked at records of gas appliances and electrical checks to see if facilities complied with statutory requirements and were safe for use. The electrical certificate was satisfactory but the gas certificate was out of date and the gas appliances should have been rechecked for gas safety by July 2015.

We asked the registered manager and registered provider about the precautions the registered persons took to reduce the risks of exposure to legionella. They told us there were no checks had been carried out either by themselves or an external contractor.

These are breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure premises and equipment were safe to use for their intended purpose and were used in a safe way;

When we returned to discuss our findings the registered provider told us he had arranged for a gas inspection and legionella checks to be carried out.

We spoke with people about the management of their medicines. People told us they felt staff supported them with medicines well. We saw medicines were managed safely. They were ordered appropriately, checked on receipt into the home, given as prescribed and stored and disposed of correctly.

We observed part of a medicines round and saw medicines were given safely and recorded after each person received their medicines. There were audits in place to monitor medication procedures and to check people had received their medication as prescribed.

Inadequate

Is the service effective?

Our findings

People told us they enjoyed the food and had a good variety of meals. One person said, "The cook is excellent. The meals are tasty." Another person told us, "We enjoy the food – lots of lovely home cooked meals."

We saw people were given drinks between meals. However staff did not make sure they drank them. During the second morning of the inspection we observed the support provided in one of the lounges. When we went in we saw six people dozing in the lounge with warm drinks in front of them. No staff were in the lounge. When staff briefly went into the lounge to assist people to and from the toilet they did not encourage people to have their drinks. Thirty minutes later a member of staff walked into the lounge said aloud, "These drinks are cold" and took them away. The member of staff did not offer people an alternative drink. We then went into one person's bedroom. A drink of orange and a cold cup of tea were untouched on a table. Staff told the registered manager that they had not been in the bedroom for about an hour.

We observed the support given to people in the dining room at lunchtime. The mealtime was relaxed and pleasant and people said they enjoyed their meal. Where someone needed assistance this was provided. However one person was not taken into the dining room at mealtimes. Staff told us the person was given their meal in their bedroom once everyone else had eaten. After other people had eaten lunch, we checked with the registered manager if the person had eaten. We had been sitting close to the person's bedroom and had not seen any member of staff go into the bedroom with a meal. She checked with staff if the person had received their meal. They had not. This put them at risk of receiving insufficient nourishment. Staff then went and gave the person their meal in their bedroom.

We spoke with the cook. She was familiar with people's likes and dislikes and told us about the special diets that were provided. She informed us how she fortified foods where people needed extra calories to assist them to gain weight. The cook told us she always cooked 'from scratch', used fresh foods and made sure the quality was good. She said she was not limited on the amount of or type of foods she could buy.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager.

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 MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to do so.

Although the home had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), the registered manager and staff team did not have a working knowledge of them. We spoke to four staff, three had not had MCA or DoLS training, one member of staff said she had training 'a few years ago' in 2012. According to the training matrix we were given, but told was out of date, only two staff had received training in MCA or DoLS. The registered manager and one member of staff had received training in 2012 but had limited understanding of MCA and DoLS. The registered manager did not have knowledge of up to date case law or how this affected people in her care.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA was not implemented in any formal way. Only one person had received a MCA assessment and one best interests' decision undertaken. One DoLs application had been authorised. However there were a number of people in Highbury House when we inspected, where a DoLS application may have been relevant because of their lack of capacity.

We saw there were restrictions in place for a number of people living with dementia including the front door being locked to keep people safely indoors. However there were

no mental capacity assessments or DoLS applications to reflect this. The management team had not made appropriate arrangements where there were concerns about a person's ability to make decisions for themselves, or to support those who lacked capacity to manage risk. In situations where the act should be, and is not implemented then people are denied rights to which they are legally entitled.

As well as restrictions in place regarding the front door being kept locked, there were other restrictions in place. One person told us the registered manager would not allow them to drink alcohol. We looked in the person's care records. There was no information regarding how this decision had been taken to restrict alcohol or the person's capacity to make decisions. The only reference to this was a diary entry in the person's care records written by the registered manager stating, 'We will not let them drink.' There was no mental capacity assessment to see if the person had capacity to decide whether to drink alcohol. Neither was there any agreement with the person, written guidance for staff or best interests' decisions.

These are breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to operate effective systems in regard to the mental capacity act and deprivation of liberty safeguards or to protect people from possible abuse.

Care records did not consistently demonstrate that people and where appropriate, their relatives were involved in making decisions about their care. People could not tell us if they were involved in consenting to decisions about care. When asked, one member of staff told us that people had not been involved in care and risk planning and these had not been updated for a long time. We could see that the information in the care records we looked at was out of date. The manager acknowledged that she was behind with some things. Where people lacked capacity, mental capacity assessments and best interests meetings had not been carried out.

One person told us they had not consented to decisions made by the registered manager about their care and choices. We looked at the person's care records to see if information was available. There was no record of any discussion of the decisions made, no record of consent, and no risk assessment. There had been no mental capacity assessment to see if the person had the capacity to make these decisions or best interests meetings carried out. We spoke with the manager who told us she had not considered whether the person had the capacity to consent to this decision or sought their consent.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to operate effective systems to get the consent and involvement of service users or their representatives for care and treatment given.

The registered manager said the training record matrix she provided to us was out of date. Therefore we agreed she could send an updated copy within two days of the inspection. However we did not receive this. This left us without up to date information about the training staff had received or when this had been undertaken.

Through records available and talking with staff we saw they had national qualifications in care. They told us they had training over the last two years in safeguarding, moving and handling, 'Dementia / lets respect' and challenging behaviour. Staff had not had training on mental capacity and DoLS and did not have sufficient knowledge in this area. We saw the two new staff had completed qualifications in care previously. They had received an induction relating to the home and some basic information about people in the home. However they were supporting people with dementia and with behaviour that challenged without knowledge of these people or guidance and training in providing appropriate care to meet these people's care needs.

One member of staff told us that they had a break from care work for several years and was just coming back into it. They told us that they had a national qualification that they had completed approximately ten years ago. We saw from their application and certificates that this was the case. However they had not received training or refreshers on dementia care, MCA and DoLS and behaviour that challenged. The registered manager told us these were planned. However we were concerned to see that the member of staff was supporting a person with behaviour that challenged without the necessary knowledge.

We saw staff had not received formal supervision for nearly two years. This is where individual staff and those concerned with their performance, typically line managers,

Inadequate

Is the service effective?

discuss their performance and development and the support they need in their role. Staff had not had formal opportunities to discuss their performance and focus on future development, opportunities and any resources needed. We asked staff about receiving supervision. They told us they did not have formal supervision. One member of staff said, "I've had appraisal a long time ago but supervisions – no they don't happen." We asked the registered manager for the staff supervision records. She gave the supervision folder to us but we saw formal supervision was last completed almost two years ago. The registered manager said she had not had time to do supervision and had got behind.

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

because the provider has failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs.

The management team had started developing the environment to assist in supporting people living with dementia. We saw measures to improve well-being and independence for people with dementia were in place. This included written and picture signs around the home to inform people of a room's use. Some contrasting coloured crockery was being used. There were plans for contrasting coloured equipment such as toilet seats. The décor on the hallway and corridor wall of the home showed pictures and murals of 'old Blackpool'. There were also old newsreels running on a large TV screen in the entrance hall. This helped to interest and assist people in reminiscing about earlier lifestyles and occasions.

Requires improvement

Is the service caring?

Our findings

Most people told us staff were very caring and kind. One person told us, "They are excellent. You only have to ask and they will help you." Another person said, "I like all the staff. They will always do their best for you. You can have a good laugh with most of them." However one person was less satisfied and said, "Most of the staff are good, but I don't get along with [one]." We also heard from relatives who told us they were satisfied with the care provided to their family member. One relative said, "It is a very friendly atmosphere. Everyone is happy and content."

People who spoke with us told us staff respected their privacy and treated them with dignity. We saw staff knocking on doors before entering rooms and speaking with people in a respectful and friendly way. One person said, "Lovely girls, so polite and friendly." A relative told us, "All the staff are lovely. They respect [my family members] privacy and they are so friendly." However we saw a member of staff take one person to the toilet in the hallway and leave the door ajar to answer the front door. This left the person sat on the toilet in full view of people. This did not promote the privacy, respect and dignity they deserved.

This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to consistently protect the privacy and dignity of service users.

As part of our observation process we watched the care and support provided around the home. This helped us to observe the daily routines and gain an insight into how people's care and support was managed. Although the inspection found some good care we also found areas of concern.

People in one lounge were able to chat to us and each other and generally occupy themselves. There was a low staff presence but people appeared quite content. In the other lounge people were less able to provide meaningful activities for themselves. Despite this there was only an occasional staff presence in the room. There were significant periods of time where people living with dementia, were left unsupervised and unsupported. We saw staff were task focused and were busy doing 'jobs' rather than interacting with people.

People in this lounge were left unsupervised and unstimulated during the times we observed care. During one period of observing care we saw one person was sat slumped over in a wheelchair for 35 minutes. Although staff 'popped in' to take three people out of the room for personal care, no one offered to assist in repositioning the person. The person was sleeping at times, at others staring ahead. During this time six people were asleep and two people passively looking down, with drinks going cold near to them. We heard one person asking a member of staff for a biscuit and being told brusquely "No we are having lunch. It's Doctors orders. No, go and sit in the dining room. We are having fish and chips."

We observed one member of staff go to a person who was asleep and abruptly asked them if they wanted to go to the toilet. They asked the person twice more before they responded and started to get up. On returning from assisting this person they moved along to another person who was dozing and told them it was lunchtime. The person looked rather disorientated and the member of staff repeated the comment. The member of staff did not give the person time to 'come to' and started assisting them to their feet. The person became unbalanced as they rose from the chair and sat down again. The member of staff assisted them by hooking their arm under the person's underarm. The person was unsteady.

In contrast, on another occasion, we saw one member of staff, briefly chatted to people whenever she was carrying out tasks in the lounge. Although only spending a couple of minutes in the lounge, this member of staff also cheerfully danced into the lounge. People were looking up and smiling in reaction to this.

The registered manager told us people had used advocacy support in the past. We did not see any information available about local advocacy services but saw one person had advocacy support.

Requires improvement

Is the service responsive?

Our findings

We talked with people, relatives and staff and observed care. People who were able to talk with us told us they had choices about their care. Relatives said they were satisfied with the home. We saw examples of personal preferences being responded to, where people were able to speak for themselves. One person said, “I can have a cup of tea whenever I want. I only have to ask.” Another person said, “Yes, the staff come and help me when I ask.”

However this did not reflect the experience of those people living with dementia or with high care needs. Where people were more dependent the choices were reduced and care was not person centred. Choices of when to receive personal care and support were limited by the staff routines. These were task centred rather than in response to people’s individual needs and preferences.

We saw social and leisure activities were limited, particularly for people living with dementia. We asked people about the choice of social and leisure activities. People who were able to entertain themselves, told us they talked and read and some people went out either alone or with family. One person told us, “We enjoy sitting and we read. We do what we want really.” However they said that there were few leisure activities arranged by the home. One person told us, “There used to be bingo and games but these have stopped.” Another person said, “Just an occasional singer. The staff are always too busy.”

We saw there was no meaningful activity aimed at people living with dementia. We observed people in one lounge just sitting\sleeping in chairs, sitting in a semi-circle, with the TV in a corner of the room. Where people were unable to occupy themselves unsupported, this made for a long and unstimulating day. The lack of meaningful social contact and companionship also increased social isolation and loneliness.

When we spoke with staff and observed care we saw that staff did not always assist people in ways that enabled them to have a choice and to meet their needs. Staff told us people who had high support needs were all up by 8am and they started getting people ready for bed after their evening meal. This did not give people options as to their rising and retiring times. Staff were unable to answer our questions about how choice and preferences were offered and recorded. Although they acknowledged that choices of when to receive personal care and support were limited by the staff routines.

Routines were task centred rather than in response to people’s individual needs and preferences. Person centred care aims to see the person as an individual, instead of treating the person as a collection of illnesses and behaviours. Person-centred care considers the whole person, taking into account each individual's unique qualities, abilities, interests, preferences and needs. It makes the rules and procedures fit the individual rather than the individual fitting the rules and procedures.

Staff acknowledged that there were not regular social and leisure activities available. They told us they occasionally sung, danced or celebrated a birthday but rarely involved people in any other activities. One member of staff said they danced with people but was unable to suggest any other activities they did.

This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to provide sufficient numbers of suitably qualified, competent, skilled and experienced persons.

We also saw in one person’s records that when they became restless going for a walk with support could reduce their anxiety. However looking at records we saw this rarely happened. We asked if staff were able to take people out who were restless and trying to leave the home. They told us this was not usually possible due to staffing levels and other tasks needing completing. This left service users without supervision and support or care that met their needs and preferences.

Another person told inspectors that the registered manager would not allow them to drink alcohol. Inspectors saw the registered manager had written they would not let them drink alcohol in their care records. The person was not involved in this decision or their needs or preferences taken into account.

These are breaches of Regulation 9 Health and Social Care Act2008 (Regulated Activities) Regulations 2014 because the provider had failed to provide care that enable people’s needs, choices and preferences to be met.

Requires improvement

Is the service responsive?

We spoke with the registered manager about how they developed care plans when people were admitted to the home. Senior staff told us care plans and risk assessments were completed soon after admission. We saw on the care records we looked they were laid out in such a way it was easy to locate information. However documentation was inconsistent.

Care files sampled showed no evidence people or their relatives were involved. Some sections of care records were in-depth and individualised to the person's needs, whilst other sections lacked detail or were inaccurate and out of date. Some information in relation to care needed and incidents that had occurred was missing.

We were told by the registered persons that only one person who was at risk if unsupported out of the home had left the home unaccompanied. However we saw from care records that two people had left the home recently on separate occasions. Neither had guidance or risk assessments in relation to this.

We saw another person had moved rooms to assist with supervision but when we looked at care records this had not been recorded in the person's care plan. Neither had the person's care plan or risk assessments been updated to reflect their increased care needs.

We saw that one person with behaviour that challenged had no written guidance in how staff should support the person. We observed that staff did not always manage the person in a consistent way. There was no guidance on how to support one person if wanting to leave the home or excessively drinking alcohol. These omissions made it difficult for staff to support people appropriately. We spoke with the registered manager who accepted that they had not made sure this information was available and up to date to assist staff to support people.

These are breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure people's requirements were continuously met through care records that reflected their assessed, monitored and updated needs.

The home had a complaints procedure which was made available to people they supported and their relatives. We asked seven people who lived at the home and five relatives if they felt able to complain and if any complaints were dealt with quickly and appropriately. Most people and their relatives said they had no complaints about the home. They told us they were aware of how to make a complaint and knew these would be listened to and acted upon. One person said, "I can talk to any of the staff and they will do their best to help." A relative told us, "I would talk to the manager and I am sure she would deal with things. Nothing is too much trouble." However one person told us they were not happy. They felt they weren't listened to and any complaints would be ignored or cause a 'row'.

We saw there hadn't been any recent complaints. The registered manager told us the staff team spoke informally with people and their relatives and this helped stop any minor issues becoming more serious concerns.

Inadequate

Is the service well-led?

Our findings

The registered manager had been in place for several years. There were mixed comments about the manager's support and management approach. Most people who lived at the home told us the registered manager was friendly and supportive. One person said, "The manager is kind and helps us." Another person told us, "The manager will always have a quick word and listen to us." Relatives said they found her supportive and approachable. One relative said, "The manager is very pleasant to us. She works hard." Another relative said, "The manager is very approachable I could go to her if I needed something." However one person who lived at the home and some staff found the management less supportive.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

The registered manager told us the views of people who lived at the home were sought. Some people who lived in the home, relatives and staff said they had opportunities to discuss their views. Others said they did not. There were formal systems in place to seek people's views. However surveys about the person's experience of living in the home had not been sought within the previous two years. Neither were there any residents meetings. This lessened the opportunity for people to voice their opinions.

Views were sought by the registered persons near the end of the inspection. The inspection team were shown views from relatives praising the home and saying they were satisfied with the care of their family members. Their views did not reflect our findings.

Similarly staff had few ways to express ideas or voice concerns. They said they had not had a staff meeting for a long time or had formal supervision. The registered manager said they had arranged staff meetings but staff had not turned up for these.

The registered manager did not show all the necessary skills and knowledge to manage effectively. They were not fully aware of and did not fulfil their responsibilities as the registered person. They did not ensure care was safe, that there was safe recruitment, sufficient staff or care was person centred. They did not have appropriate knowledge in relation to the law on Mental Capacity Act and DoLS.

There was some auditing of accidents and critical incidents to highlight the number of falls people. However this was not always accurate. Neither was the data used to inform practice, alter staffing and reduce risks.

Systems were not in place to check environmental health and safety processes were monitored and maintained. Safety checks were not carried out and the environment on the inspection was unsafe with water too hot to touch in bathrooms and legionella and gas checks were not carried out as they needed to be. These were dealt with after the inspection so there was not an immediate risk to people.

The registered manager had involved people who could provide guidance about dementia, and improved some aspects of the environment, However they were not following current good practice particular for activities and daily living for people living with dementia.

The registered provider worked in the home on a frequent basis and had regular meetings with the registered manager. Although there were systems in place to assess and monitor the quality and safety of the services provided, these were not operated effectively. The systems that could have been used included audits of the environment, care records, staff records, medication and falls. The Falls audits had been carried out but there was no evidence that these were evaluated for lessons learnt or affected care practice.

Neither the registered provider or registered manager carried out formal quality assurance to ensure they knew how the home was operating. Infrequent environmental audits were carried out until the end of 2014 then stopped until one environmental audit was completed in August 2015. The environmental audits had not identified any infection control issues. Two medication audits had been partially completed in September and October 2015. The registered manager acknowledged that the audits systems were in place but said she had not had time to complete these.

Systems were in place to monitor the home but were not used. This reduced the opportunity to learn from events such as complaints, concerns, whistleblowing and

Inadequate

Is the service well-led?

investigations. There were several breaches of regulations which neither the registered provider nor registered manager had identified through audits or informal monitoring.

These are breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to assess, monitor and improve the quality of services, mitigate risks relating to health and safety and ensure systems or processes were operated effectively to ensure compliance with the regulations.

Although the registered manager had notified CQC of one death, and a DoLS approval, they had not notified CQC of other deaths, safeguarding concerns or incidents reported to or investigated by the police as they were required to do. We looked at records in the home and saw there had been six deaths since April 2015. We checked our records and saw that we had not been notified of five of these. We asked the registered manager about these. She told us she had forgotten to send us notifications of the five deaths. We looked at care records and saw instances where people had gone missing from the home and incidents reported to or investigated by the police. We checked our records to see if we had been notified of these. We had not. We asked the registered manager about these. She told us she had not notified us of the safeguarding issues or of incidents reported to or investigated by the police.

These are breaches of Regulation 16 and Regulation 18 Care Quality Commission (Registration) Regulations 2009 The provider/registered manager had failed to Notify CQC of the death of service users, safeguarding concern or any incident which was reported to, or investigated by, the police.

We had responses from external agencies including the local authority contracts and commissioning team about the home. We also contacted Healthwatch Blackpool. Healthwatch have the statutory power to enter and view health and social care services.