RYSA Highfield Manor Limited

# Highfield Manor Care Home

## Inspection report

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13 January 2016
14 January 2016
15 January 2016
18 January 2016

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## Ratings

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

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

# Summary of findings

## Overall summary

This inspection took place on 13, 14, 15 and 18 January 2016 was unannounced. The inspection was carried out in response to concerns received, and changes in the management arrangements at the home.

We last inspected Highfield Manor Care Home in July 2015 and we identified serious shortfalls and breaches of the regulations. The home received an overall rating of Inadequate at that inspection.

Highfield Manor is registered to provide personal care for up to 46 people living with dementia. Nursing care is not provided. There were 27 people living at the home at the time of the inspection.

There was not a registered manager at the home. One of the deputy managers was acting as interim manager. In addition there was a newly appointed prospective service manager who was considering whether to apply to be registered. The previous registered manager, who was also a director of the registered provider, cancelled their registration in August 2015. They have continued to have a daily presence in the home. A manager had been appointed in September 2015 but they did not register and they left the home in January 2016.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last comprehensive inspection in July 2015 this provider was placed into special measures by CQC. At this inspection we found that there was not enough improvement in the service to take the provider out of special measures.

In addition to placing the service in special measures in July 2015 we imposed an urgent condition on the provider's registration. This means further people cannot move into the home or return from hospital without our agreement. This was because people's care was not assessed, planned for and was not provided in a safe way. People's nutritional needs were not met and this placed them at risk of harm.

We have requested the provider send us an action plan every month to tell us what action they have taken to meet all of the shortfalls identified at the July 2015 inspection.

At this inspection we identified continued serious shortfalls and 10 repeated and three new breaches of the regulations. The service met the previous breach of the regulations in relation to recruitment of staff recruitment. Some improvements were seen in the support and training staff received.

We identified safeguarding concerns during the inspection and raised three safeguarding alerts with the local authority, who are responsible for investigating any allegations of abuse.

CQC is now considering the appropriate regulatory response to the shortfalls we found. Where providers are not meeting the fundamental standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

Any risks to people's safety were not consistently assessed and managed to minimise risks. For example, plans and the support were not in place to manage the risk for people who had multiple falls and sustained injuries, and those people who needed support to mobilise safely or to be moved using equipment such as hoists. These shortfalls were repeated breaches of the regulations.

People's needs were not reassessed when their circumstances changed and care plans were not updated or did not include all the information staff needed to be able to care for people. Staff did not consistently follow care plans. People did not always receive the supervision, care and treatment they needed and this placed them at risk. People particularly at risk were those people living with dementia, those who were nutritionally at risk, and those with complex physical care needs. Some people's health care needs such as pressure area care, pain management and dental and foot care were not always met because the healthcare support they needed was not delivered. These shortfalls were repeated breaches of the regulations.

A small number of people were not always treated with respect and their dignity was not maintained. This was a repeated breach of the regulations. Overall, staff were caring and were respectful in the way they treated and spoke with people.

People's medicines were not always safely managed or administered. This was because staff did not have clear instructions when they needed to give some people 'as needed' medicines. Some people may have received 'as needed' sedative medicines when they did not need it. This was because the reasons for administration had not been recorded for some 'as needed' medicines. The shortfalls in medicines management was a repeated breach of the regulations. Medicines were stored safely.

People's mealtime experiences were improved from the last inspection. However, some people did not all receive the monitoring, support and fortified fluids and food they needed to increase or maintain their weight. This was a repeated breach of the regulations.

There were not consistently enough staff to meet people's needs. This was because some people at the home needed two or three staff to safely care for them. This was repeated breach of the regulations.

Staff did not know enough about people as individuals to be able to provide personalised care.
Some people who were cared for in their bedrooms did not have anything to occupy or stimulate them that was based on their individual needs and preferences.

Some people living with dementia were not able to find their way around the building. The building was not suitable for people living with dementia and did not take into account national good practice. This was a repeated breach of the regulations.

Staff still did not fully understand or adhere to the principles of the Mental Capacity act 2005. This was a repeated breach of the regulations.

Some people were being deprived of their liberty and had Deprivation of Liberty Safeguards (DoLS) applications or authorisations in place. Some people's conditions in relation to their authorisations were

not being met and one person was being deprived of their liberty unlawfully. This was new breach of the regulations.

Complaints information was not displayed and there was no consistent system for investigating, managing and responding to complaints. This was a repeated breach of the regulations

We were not notified about allegations of abuse at the home, some actions from safeguarding meetings were not completed and learning and outcomes were not shared with staff. This was a repeated breach of the regulations.

The provider had not notified us of all of the significant events that had happened at the home. This was a new breach of the regulations.

The home's inspection rating was not displayed and a copy of the report was not made available to people and visitors. This was a new breach of the regulations.

The home was not well-led. The management consultant told us they were not able to fully manage the service. The provider had been providing us with a monthly action plan as to how they were going to meet the regulations. This and other information provided to CQC was inconsistent and was contradictory to the findings of the inspection.

There were some improvements in the overall care that people were receiving. However, the management of the home was still reactive rather than proactive. When we identified shortfalls, safeguarding concerns and risks to people they were addressed. New management consultants were appointed during the inspection.

The systems in place for assessing and monitoring the quality and safety of the service were still not effective. This was because the shortfalls we found had not been identified by the service.

Record keeping had improved but there were still shortfalls in the accuracy of records kept about people.

The shortfalls in the governance of the home were a repeated breach of the regulations.

Staff were warm, friendly and caring towards people. Staff smiled with people and gave them time to say what they wanted to. They spoke about people with a genuine fondness and they were concerned about their general wellbeing. Staff told us they believed people were now getting good quality care.

People enjoyed the individual and group activities provided in the main lounges by the activities workers and care staff.

Staff recruitment practices were safe and relevant checks had been completed before staff worked with people. Some staff told us they had attended training since the last inspection. Staff felt better supported and they had formal one to one supports meeting. Some staff had received an annual appraisal to review their performance. However, this was not consistent across the staff team and this was an area for improvement.

## 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**

People were not kept safe at the home.

Risks to people were not managed to make sure they received the correct care they needed.

The management and administration of medicines was not consistently safe.

There were not always enough staff on duty.

Staff were recruited safely.

Staff knew how to report any allegations of abuse.

### Is the service effective?

**Inadequate**

People's needs were not met effectively.

People's rights were not effectively protected because staff did not understand or adhere to the Mental Capacity Act 2005.

Some people did not receive the fortified food and drinks they needed to make sure their nutritional needs were met.

Some people's health care needs were not met to ensure that they kept well.

People were referred to specialist healthcare professionals when needed such as dieticians.

Staff were better supported and trained.

### Is the service caring?

**Requires Improvement**

The service was caring but needed some improvement. This was because staff did not always respect some people's dignity.

People and their relatives told us staff were kind and caring.

Staff were fond of the people they were caring for.

## Is the service responsive?

Inadequate

The service was not responsive to people.

People did not always receive the care they needed, staff did not always follow care plans in place, people's care plans were not always updated and did not include all the information about their care and support needs. This meant staff did not have up to date information about how to care for people.

Relatives knew how to make a complaint but the complaints systems were inconsistent.

People enjoyed the individual and group activities provided in the main lounges by the activities workers and care staff.

## Is the service well-led?

Inadequate

The home was not well-led.

There were ineffective systems in place to monitor the quality of the service and drive forward improvements.

The culture at the home was reactive rather than proactive.

There were shortfalls in the records kept and they were not accurate.

The rating for the service was not displayed so people and their visitors knew that the home was rated Inadequate.

# Highfield Manor 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 13, 14, 15 and 18 January 2016 and was unannounced. The inspection started at 3.30pm and finished at 8pm on 13 January 2015. The following days of inspection were undertaken between 9.30 and 4pm. There were three inspectors in the inspection team. Three inspectors visited on the first three days and two inspectors on the final day.

We met and spoke with all 27 people living at Highfield Manor Care Home. Because some people were living with dementia we 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 spoke with eight visiting relatives, two visiting social workers, two continuing healthcare assessors and a district nurse. We also spoke with the management consultants, interim manager, deputy manager, prospective service manager, directors of the provider and 18 staff.

We looked at four people's care and support records and care monitoring records in detail, at monitoring records and specific elements of six other people's care plans. We looked at all 27 people's medication administration records and documents about how the service was managed. These included four staff recruitment and six staff supervision and training records, the staff training overview record, audits, meeting minutes, maintenance records and quality assurance records.

Prior to the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was returned by a director of the provider on 10 December 2015.

Before our inspection, we reviewed all the information we held about the service. This included the information about incidents the provider had notified us of, the provider's monthly action plans, safeguarding meeting minutes and the Provider Information Return (PIR).

We did not contact any commissioners because the majority of people living at the home funded their own care. We contacted the local authority safeguarding team for an update on outstanding safeguarding allegation investigations.

Following the inspection, the interim manager and prospective service manager sent us information about policies and staff qualifications.

Inadequate

# Is the service safe?

## Our findings

Because most people were living with dementia they were unable to tell us whether they felt safe. We observed people responding positively with smiles when staff approached them. This showed people felt relaxed with staff. Some people who were able to told us they felt safe at the home. Relatives said they did not have concerns about their family member's safety and felt they were safe at the home. However, we identified areas of concern that impacted on people's safety.
At our inspection in July 2015 we raised safeguarding alerts for some individuals and the whole of the home because of the serious shortfalls we identified. The shortfalls in protecting people from abuse and improper treatment and the lack of effective systems and processes for investigating and reporting allegations of abuse were a breach of the regulations.

The provider, management consultants and previous manager had fully co-operated with the local authority who investigated the allegations. The local authority safeguarding team have continued to visit, investigate concerns and monitor the home on a regular basis.

At this inspection we identified three people who were at risk of harm and neglect and made safeguarding alerts to the local authority. The management team took immediate action once we had identified these safeguarding concerns to them. However, they had not identified these concerns themselves.

Information about safeguarding adults from abuse and how to report allegations was displayed in communal areas. The training records showed that not all staff had been trained in recognising and reporting allegations of abuse. This contradicted the information submitted to us in the provider information review (PIR) and the provider's November 2015 action plan. These documents stated that all staff had been trained.

Providers are required to notify us of any allegations of abuse at the home. The previous manager had notified us of one allegation and had taken appropriate action to safeguard the person. However, we did not receive any other notifications about all allegations of abuse that were investigated by the local authority. For example, we identified an allegation of abuse in complaint records that had been referred to and investigated by the local authority but we had not been notified.

Some actions identified at local authority safeguarding meetings were not completed. For example, In October 2015 the local authority requested that the provider's representatives completed a one to one supervision with a member of staff. However, we saw from records the concerns raised at the meeting had not been addressed with the staff member. In addition, the provider's representatives (management consultant) had been asked to undertake an investigation into an allegation of abuse. The provider annulled the management consultant's contract during the inspection before the investigation was complete. This meant the investigation was not completed, appropriate action was not taken and this potentially continued to place people living the home at risk.

Information, the outcomes and learning about safeguarding investigations had not been shared with staff.

This meant staff may not have been fully aware of the actions needed to minimise the risks and improve the care and support to people.

These shortfalls in protecting people from abuse and improper treatment and the lack of effective systems and processes for investigating and reporting allegations of abuse were a repeated breach of 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in July 2015 we found shortfalls in the risk management of people, medicines management, ensuring the premises are safe and ensuring that staff had the competence, skills, qualification and experience to safely provide care to people. These shortfalls were a breach of the regulations.

At this inspection we looked at the medicines management systems in place at the home. Medicines were stored safely and there were systems in place for storing medicines that needed refrigeration. Some liquid medicines were dispensed in single dose sealed pots. This reduced the risks of liquid medicine administration errors. We checked the medicine storage and stock management systems in place. We checked the stock for some specialist medicines and found the stock and the medicine record book balanced for those medicines. However, these specialist medicines and record book had not been audited since October 2015. Some specialist medicines in the record books did not include whether they had been audited at all.

The interim and deputy manager were responsible for the medicines in specific areas of the home. The interim manager was responsible for people's medicines on the lower basement and ground floor, and the deputy manager took responsibility for people's medicines on the first and second floor. The interim manager showed us they audited the medicines they were responsible for every week. In addition the previous manager had completed a sample audit of these audits. However, a monthly medicines audit had not been developed as stated in the provider's monthly action plan.

Two people did not have a PRN (as needed) medicine plans in place so that staff knew when and how often to administer these medicines. The interim and deputy manager took immediate action and put the plans in place.

Some people were prescribed PRN medicines such as sedative medicines to be used when they were upset or unsettled. They were to be used when staff had not been able to reassure the people as directed in their care plans.

One person, who was living with dementia, had been routinely given their PRN sedative at night. The reason for administration had not been recorded and records did not reflect that the person had been routinely unsettled or upset. The person's GP had been contacted in November 2015 by the deputy manager because staff were routinely using this medicine. However, no follow up about this had been sought since November 2015 to make sure they should continue to administer the medicine in a regular basis. This person had also had two recent falls in the evening and overnight and this information had also not been considered to prompt a request to review their medicines.

Another person, who was living with dementia, had also been given PRN sedative medicines and the reason for administration was not recorded. We reviewed this person's records and saw that there some occasions when the person had been unsettled. These times usually related to when they were receiving personal care and they were more relaxed later. However, we noted that the person had been given their sedative medicine at other times when no concerns were recorded.

A third person, who was living with dementia, was prescribed an inhaler to use when they were wheezy and breathless. The medicine administration records showed they had been given this inhaler 13 times over a five day period. However, the reason for administration was not recorded. The interim manager told us they had administered the inhaler because staff had reported to them the person was wheezy and chesty. However, this was not recorded anywhere in the person's records.

Risks to people were not fully assessed and management plans were not always in place or followed by staff to minimise these risks. For example, one person had two recent falls. Their falls risk management care plan included that a sensor mat would be used in their bedroom to alert staff when they got out of bed or moved about their bedroom. However, this sensor mat was not in place. This meant staff had not been alerted when the person was moving about in their bedroom and they subsequently did not find the person until they had fallen. The person sustained a fractured shoulder as a result of the first fall.

Another person's moving and handling risk management and care plan included that three staff were required to safely move them in the hoist. However, records showed that on two days only two staff had moved them. This placed the person at risk because staff had not followed the risk management plan in place.

A third person had a crash mat and bean bag placed by their bed. Records showed and staff told us the person would get themselves onto the bean bag but they were not able to get out of it independently. A staff member told us they then had to help them out of it. This person needed staff support to safely mobilise by using a hoist. However, there was not any risk assessment or management plan of how they were to assist the person out of the bean bag using the hoist. This placed the person and staff at risk. This was because there was not a plan in place to instruct staff how to safely move the person.

A fourth person had bed rails in use at night but there was no risk management plan in place for these. A fifth person's plan stated they used bed rails but these were not being used due to risks of them climbing over them. This meant there was a risk that staff may use the bedrails and the person may have climbed over them.

At our inspection in July 2015 we found staff were not able to effectively communicate with people because their first language was not English and they did not have the skills and knowledge about dementia care.

At this inspection the staff employed either had English as their first language or had a working understanding and use of English. Overall, staff were able to understand and respond to our questions with some rephrasing. People and relatives told us in the main they were able to effectively communicate with staff. This was an improvement from July 2015. Some staff had received training in dementia care. However, overall most staff still did not have an understanding of providing person centred care that was based on good practice in dementia care.

These shortfalls in the risk management of people, medicines management, and ensuring that staff had the competence, skills, qualification and experience to safely provide care to people were repeated breaches of Regulation 12 (2) (a) (b) (c) (d) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in July 2015 we found there were not enough staff to meet people's needs and this was a breach of the regulations.

At this inspection one person told us the staffing levels were not as good as they used to be and this had an

impact on how quickly staff responded to call bells. Another person who was uncomfortable in bed told us not to worry getting the staff because they were busy and they would be back in while to see them. We sought staff attention for this person to make them more comfortable.

There were not consistently enough staff to meet people's needs. This was because 10 people needed two staff for some aspects of their personal care and or to move them safely and one person needed three staff to provide personal care and to safely move them with a hoist. Other people who were living with dementia needed ongoing monitoring and support.

At our inspections in October 2014, January 2015, March 2015 and July 2015 we identified there was not any system in place for identifying how they calculated the staff numbers needed to meet the needs of the people living at the home. The provider's action plan included they were using a recognised staffing level tool. At this inspection there was a dependency tool in use to calculate the staffing levels. However, this was not effective as it did not accurately consider the numbers of people who needed two and three staff to safely move them or provide personal care or include any information how the staffing hours were then calculated.

During the first and second day of the inspection additional staff were called in following our arrival at 3.30pm. For example, one member of staff who was scheduled to come in at 8pm to 10 pm. They told us they had been telephoned and asked to come in at 4pm to administer medicines. They said they would also be sleeping in at the home because the night staff on duty were not trained to administer medicines. However, this extra sleep in was not scheduled on the rota.

On third day of inspection there were not enough staff to meet people's needs. This resulted in people experiencing delays in care. For example, one person, who was living with dementia, asked us to get up at 11.11am and we told staff immediately. This person had been incontinent of faeces and some faeces was on their hands and on their bedroom wall. Staff told us they needed to wait for another member of staff to be able to get them up. Two different members of staff went into the person at two different times but did not get them up. Staff did not get this person up for over another hour and a half until 1pm because staff were not available or were getting other people up.

On the third day of inspection there was only one member of staff on duty who was administering medicines in the morning. This staff member was also needed to provide support with moving one person who needed three staff to support them with this. They were still administering people's morning/breakfast medicines at 10.50 am and some people's medicines were due again at lunchtime. This meant there were not enough medicines trained staff on duty to ensure people received their medicines as prescribed.

Staff were working excessive hours at the home and mostly worked 12 hour shifts. For example, one member of senior care staff had worked 87 hours in the week of the inspection without adequate rest breaks in between. Most of the care staff had worked over 50 hours that week. Of the five staff files we reviewed only one file included the 48 hour working week opt out declaration. This meant of the four remaining staff, three of them were working over the 48 hours set by the 'working time regulations'. This was a breach of these regulations.

The shortfalls in staffing were a repeated breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in July 2015 we found shortfalls in the recruitment of staff. This was a breach of the regulations.

At this inspection we looked at four staff recruitment records. Recruitment practices were safe and the relevant checks had been completed before staff worked unsupervised at the home. These checks included the use of application forms, an interview, reference checks and criminal record checks. This made sure that people were protected as far as possible from staff who were known to be unsuitable. This was an improvement.

The provider told us in their PIR that 'People who use the service are involved in the recruitment of staff and receive training and support to do this. The service is proactive rather than reactive in its staffing, recruitment and training.' We asked the management consultant and interim manager about recruitment. They confirmed they were involved in the recruitment of most staff but that people who lived at the home were not. This meant the information provided to us was incorrect.

The interim manager told us a legionella risk assessment had been recently completed and agreed to send us this document. However, this was not received at the time of writing the report. They told us there was a system for flushing the system and running of taps in empty bedrooms. They acknowledged this had only been implemented in December 2015.

At our inspection in July 2015 we found some areas of the home to be very hot. We identified this as an area for improvement because the provider gave us assurances they had purchased air conditioning units. In addition, the monthly action plans submitted by the provider included there were daily temperature checks on each floor being completed and recorded. However, the interim manager confirmed this was not happening because there were not enough thermometers in the home. They said and records showed the only temperatures being recorded were in the medicine rooms.

The provider told us in their monthly action plans that there were weekly health and safety checks being undertaken. However, the interim manager was not aware of these and records of these checks could not be located. The prospective service manager had completed a health and safety audit the week prior to the inspection.

Inadequate

# Is the service effective?

## Our findings

At our inspection in July 2015 we identified people were not supported to eat and drink as directed by in their safe swallow plans written by their speech and language therapists (SALT). People's foods and fluids were not monitored and food and fluids were not available in the lower basement. This was a breach of the regulations.

During the first day of this inspection one person's fluids were not thickened as detailed in their SALT plan. In addition, there was a piece of cake left in the person's bedroom. This person was only to have fluids thickened to a syrup consistency and their foods were to be mashed. Staff were aware that the person needed to have their fluids thickened but were not able to provide and explanation as to why it was not to the correct consistency. The unthickened fluids and cake being in this person's bedroom placed them at risk of choking and aspiration because staff may have given these to the person. We fed this back to the management consultant and interim manager. The interim and deputy manager took immediate action and placed the person's SALT plan in their bedroom. Fluids were thickened for the remainder of the inspection.

For the first two days of inspection drinks were not available in the lower basement and first floor lounge so people could help themselves. People were reliant on staff giving them drinks when the drinks trolley was taken to these floors from the main kitchen. Cold drinks were freely available at all times on the ground floor.

People's weights were being monitored and reviewed on a weekly or monthly basis dependent on risk. Most people's weight was stable or they had put on weight. Some people had lost weight and referrals were made to the dietician for advice.

Records showed and the cooks told us the names of people who they were providing fortified diets for each day. However, this did not include one person whose had lost 8 kg over an eight month period. This person was having a prescribed food supplement following the dietician's review of their weight loss in January 2016. However, they were not having any fortified foods and drinks, (such as full fat cream, full fat milk, or full fat cheese added to their meals) to increase their weight as detailed in their care plan.

The interim and deputy managers acknowledged that they had been reviewing the person's BMI and weight but had not identified the overall weight loss of 6 kg before November 2015 when they made a request to the GP for a dietician referral. The person had lost a further 2kg since November 2015. In addition to this weight loss this person's bottom dentures had been missing since July/August 2015. The person told us their mouth was sore, their top dentures did not fit and they were waiting to see a dentist. They said, "it affects my eating it's terrible I've lost all my weight". This information was supported by the person's visiting relative. This meant this person's nutritional needs were not being met.

One person was vegetarian and kitchen food records showed they had been given red meat products four times in January 2016. This was not in accordance with the person's recorded wishes and preferences.

Some people living with dementia were offered visual and verbal choices of food but this was not consistent throughout the inspection. This meant some people living with dementia were not given a choice of food in a way they could understand.

Photographs of the main meal of the day were displayed in each lounge area so people knew what was for lunch. However, this was not changed after lunch to show what the tea was.

These shortfalls in meeting people's nutritional and hydration needs were a repeated breach in Regulation 14 (1) (a)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff supported people to eat and drink in a relaxed way and at their pace. There was an improvement in the overall monitoring of people's food and fluid intake. Where people's fluid intake fell below the recommended amount there was a written prompt to increase the person's fluid intake the next day.

Snacks of cakes, fruit and sandwiches were available on each floor in small Perspex covered trays. Staff offered these to people throughout the inspection. Some people had fed back at a 'Residents Meeting' in January 2016 that they liked that they could help themselves to the food.

Coloured crockery was used throughout the home. This was good practice and research has shown that people living with dementia can see food more easily on coloured crockery and may subsequently eat more. Some people preferred to use china crockery and this choice was respected.

At our inspection in July 2015 we identified shortfalls in people's pain assessment and management and people's pressure area care.

Most people's day to day health needs were met. We saw examples of where people had been referred to the GP, district nurses, community mental health teams and dieticians. However, some people's healthcare needs were still not effectively met.

Concerns were raised with staff at the home by a visiting professional that one person was very sleepy at the beginning of December 2015. We reviewed this person's records and saw they continued to be sleepy after this was identified. However, the GP was not contacted by staff at the home until 14 days later. This meant there was delay before medical advice was sought. The person's medicines were then reviewed and changed by the GP and they had further blood tests which identified they were anaemic.

The interim manager told us no one was being treated by the district nurses for any pressure ulcers. Records showed and staff told us people were being repositioned as detailed in their care plans to minimise the risk of pressure damage to their skin.

Records showed specialist air mattresses were monitored on a daily basis. However, these records did not consistently show for all people what the setting the mattress should be set to. This meant where the setting was not recorded staff were only checking the mattress was working and not whether it was on the correct setting for the person.

Two people's feet were pressing on the base of their beds. These people were not able to move or reposition themselves. There was not anything placed between their feet and the bed base to protect their feet from pressure areas. This placed them at risk of developing pressure areas on their feet.

A private chiropodist visited the home on a six weekly basis and provided foot care to all of the people living

at the home. One person's toe nails were visibly long. We reviewed the chiropodist's records and saw this person had incomplete treatment to their left foot only in November 2015 and then refused treatment in December 2015. This meant their toe nails on their right foot had not been cared for since October 2015. The deputy manager acknowledged that this person's toe nails looked long. The chiropodist's next visit was due at the end of January 2016 but no actions had been identified or taken to ensure foot care was provided to this person.

People who had pain from health conditions did not routinely have their pain assessed using a recognised pain assessment tool. These tools are used to assess people's pain levels if they cannot verbalise if they are in pain. People living with dementia may not always be able to say or show when they are in pain. One person living with dementia had fallen and fractured their shoulder. Their pain was only being assessed once a day and not throughout the day and night. They subsequently did not receive pain relief consistently throughout the day and night. We brought this to the attention of the interim manager who contacted the GP. Additional pain relief was prescribed following the use of the pain assessment tool which identified the person was in pain from their fractured shoulder.

Another person living with dementia was prescribed PRN 'as needed' pain relief but their pain was not being assessed more than once a day. Other people only had their pain assessed once a month. This meant some people living with dementia may not have been received pain relief when they needed it. Action was taken following us identifying this shortfall on the first day of inspection and people who needed their pain assessed had this completed. However, this had not been identified by the staff at the home prior to our inspection.

These shortfalls in accurately assessing, planning and meeting people's care needs were a repeated breach of Regulation 9(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with a visiting district nurse and the clinical commissioning group prior to the inspection and they did not have any current concerns about people living at the home. The district nurse told us the staff at the home were seeking advice appropriately. In addition we spoke with two visiting health and social care professionals who were assessing a person for continuing healthcare funding. They also told us they did not have any concerns about the service.

At our inspection in July 2015 we found the service was not fully meeting the requirements of the Mental Capacity Act 2005. Staff were not fully aware of the Mental Capacity Act 2005, making best interest decisions, or who had Deprivation of Liberty Safeguards (DoLS) applied for or authorised. This was a breach of the regulations.

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.

At this inspection some people had mental capacity to make their own decisions. However, consent records had been signed by a relative rather than the individual. Where people lacked mental capacity to make a specific decision, in general, mental capacity assessments had been completed. However, the records relating to decisions that had been made in their best interests were not wholly accurate because they did not show who had been involved in making the best interests decision. In addition, one person had moved bedrooms. There was evidence that the service had discussed this with a relative, but there was no mental capacity assessment, or decision made in accordance with the statutory best interests checklist.

These shortfalls of acting in accordance with the Mental Capacity Act 2005 were a repeated breach of Regulation 11 (1) (2) (3) (4) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in July 2015 the management team did not have robust system for reviewing when people's DoLS authorisations were expiring and/or taking action if people's mental capacity improved and they could make decisions about where they lived. This meant that some people may have been subject to DoLS when this was not needed. This was an area for improvement.

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). These safeguards can only be used when there is no other way of supporting a person safely. The responsibility for applying to authorise a deprivation of liberty rested with the manager. We looked at whether the service was applying the DoLS appropriately.

At this inspection there was a system in place to make sure people who were deprived of their liberty were protected, however, the system was not effective. Two people had conditions attached to their authorisation that had not been met. The home had not checked that these conditions were being met until we drew this to their attention. We asked the service to take action to ensure these people's conditions were adhered to.

One person had been subject to a DoLS that had expired in October 2015. Although the individual continued to be subject to restrictions amounting to a deprivation of liberty, a further application to the supervisory body had not been made. This meant the individual was unlawfully deprived of their liberty. Managers were not aware of this until we drew it to their attention and requested that they take immediate action to protect this person's rights.

When a person dies, who is subject to or an application has been made for a DoLS, a referral needs to be made to the coroner. The deputy manager told us they were aware of this requirement. Following the inspection we requested information about people who this applied to. This basic information was sent to us but when we asked for further details so we could establish whether the death of these people had been referred to the coroner this information was not provided.

These shortfalls in people being deprived of their liberty unlawfully were a new breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspections in October 2014, March 2015 and July 2015 we identified the premises were not suitable for people living with dementia. We reported at all inspections that improvements could be made with respect to signage in the home so people could identify and recognise toilets, bathrooms and bedrooms.

At this inspection some people's bedrooms and bathrooms and toilets had some signage. However, this was not in a format or supported by pictures or photos so that people living with dementia could easily recognise the toilets and their bedrooms. For example, one person was stood outside their own bedroom looking for the toilet. Their bedroom had their name on it but the person was not able to recognise this. They asked us for help and we showed them where their bedroom and ensuite bathroom was. Another person in the lower basement was also not able to recognise the signage or orientate themselves and asked us for help to find a toilet.

Action still had not been taken to make the physical environment of the home accessible to people living with dementia and national best practice and guidance had not been taken into account. For example,

bathrooms and toilets did not have contrasting coloured toilet seats so that people living with dementia and poor eyesight could recognise where the toilet was in the rooms.

The shortfalls in the suitability the building were a repeated breach of Regulation 15 1 (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us things had improved at the home and they had been better supported by the previous manager who left at the beginning of January 2016.

Staff told us and records showed they had a one to one supervision sessions with the previous manager or management consultant. However, some staff who had worked at the home for over a year had not had an annual appraisal to evaluate their performance and identify any learning needs. For example, the last appraisal for the deputy manager was in 2007.

Staff told us they had received more training since the last inspection. We saw that training in pressure care, fire safety and basic life support was booked. Training on dementia care, manual handling, food hygiene, infection control, palliative care and equality and diversity had been provided to some staff. The training record provided during the inspection was contradictory to the information submitted by the provider in their PIR. For example, the PIR included that all staff had completed dementia care training. However, the training matrix showed that only 10 of the 22 staff had completed this.

Two of the care staff had achieved national vocational qualifications (NVQ) in care. Four care staff were in the process of completing these national vocational qualifications and three of them anticipated completing this in February 2016. The provider sent us information following the inspection that included five staff were completing the care certificate, which is a nationally recognised induction qualification. However, this information did not include all of the staff appointed since the last inspection. In addition the information provided during and the following the inspection differed to the information submitted in the provider's PIR. This meant it was difficult to fully assess what training staff had received, how many staff had achieved NVQ's and how many had started or completed the care certificate.

Although there were some improvements in staff receiving some training, appraisals and supervisions this was not consistent across the staff team. Staff had improved skills in meeting the physical and personal care needs of some people. Further improvement was still needed in staff being able to provide personalised care to meet the social, emotional, stimulation and wellbeing needs of people living with dementia at the home.

Requires Improvement

# Is the service caring?

## Our findings

One person told us, "The staff are all very caring" and another person said the care was, "Reasonable".

Relatives said staff were caring and kind. One relative said, "They're really lovely and we're completely happy with everything. There's a friendly atmosphere and they always listen to us". Another relative commented on staff members that knew their family member well, "They (three named staff) are very good they have looked after her for two years. She responds particularly well to (staff member)". A third relative said about staff, "They are caring and kind, they do their best and they are patient". A fourth relative told us the staff, "Are absolutely brilliant, very patient and always friendly".

At our inspection in July 2015 not all of the staff were caring in their approach to people.

At this inspection, staff were warm, friendly and caring towards people. Staff smiled with people and gave them time to say what they wanted to. They spoke about people with a genuine fondness and they were concerned about their general wellbeing. Staff told us they believed people were now getting good quality care.

At our inspection in July 2015 people were not treated with respect, their dignity was not maintained and their independence was not promoted.

At this inspection most staff treated people with respect and maintained their dignity. For example, when a person's drink came out of their mouth staff sensitively and discreetly wiped the person's mouth and chin because they were not physically able to. However, this was not consistent. One member of staff referred to people living with dementia who needed support to eat and make choices as "the feeds" and "the awkward ones". They explained this further by telling us this was because the people were not able to make a verbal choice. A care worker described one person with complex mental health needs as "playing up" and "like a child".

One person was left with faeces in their nails and on their bedroom wall for over one and half hours. Another person was not supported to the toilet and they became distressed when they had an accident. This meant some people's dignity was not maintained.

We saw some staff encouraging one person to fold napkins to be placed on the tables. However, overall people's independence was not actively promoted. We did not see people being involved in activities of daily living such as making drinks, laying tables or helping with other tasks around the home.

These shortfalls in treating people with dignity and respect and promoting their independence were a repeated breach of Regulation 10 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in July 2015 we identified concerns about the end of life care being provided to one

person. This person's condition had improved since the last inspection. At this inspection there was not anybody receiving end of life care at the home. This meant we were not able to assess whether there were any improvements in this area.

At our inspections in October 2014 and July 2015 we found that relatives were not free to visit their family members when they wanted to. We identified this as an area for improvement. At this inspection relatives told us they were free to visit the home whenever they wanted to.

Inadequate

# Is the service responsive?

## Our findings

At our inspection in July 2015 we found some people were not receiving the support they needed to meet their care and emotional well-being needs. In addition, people's needs had not been assessed and care plans had not been put in place or they had not been followed. This was a breach of the regulations.

At this inspection most staff responded to people and their requests. They were quick to respond to people's needs. However, some staff were focused on tasks rather than responding to the people they were caring for. For example, we had advised staff that one person had told us they wanted to get up. This person needed two staff to assist them. However, the two staff went to get up another person up, who was asleep at that time, rather than the person who had requested to get up. The staff did not respond or acknowledge this person when we could hear them calling out "come on, come on" and later they called out "hurry up" from their bedroom.

Staff were knowledgeable about people's physical and personal care needs. However, none of the care staff were able to tell us about the people as individuals, what and who was important to them and any of their personal history.

The staffing shortfalls meant they were not always responsive to people's needs. For example, in the lower basement two people were sat in the lounge area. One person was distressed and indicated to us they wanted the toilet. We looked for staff with the person but there were none available. We walked with the person to the nearest toilet. However, because they were living with dementia, they were not able to recognise the toilet and urinated on the floor. The person was very distressed about this and we stayed with them to comfort them until staff arrived.

People's needs had been reassessed since the last inspection and new care plans had been developed. Overall the care plans were personalised and gave staff clear direction as to how to care and support people. However, some people's care plans were not consistently followed by staff and did not include all of the areas of a person's needs. This meant staff did not have all of the information they needed to be able to provide the right care and support to people.

Some but not all people had life histories and information recorded about what was and had been important to them. However, staff were not aware of this information and one staff member told us they did not have time to read people's care plans where this information was recorded. Staff did not understand the importance of people's preferences and past experiences in planning and delivering care to meet their emotional and well-being needs.

Peoples' care plans were reviewed on a monthly basis. However, these reviews did not consistently identify whether the care plans were accurate, whether people's needs had changed or whether staff were delivering the care included in the care plan. For example, one person's care plan that had been written in October 2015 included the person had a rectal prolapse and instructed staff to undertake an invasive nursing procedure. This home does not provide nursing care and there was a risk of harm to this person if staff had

followed this care plan. This care plan had been reviewed every month but it had not been identified that the information was incorrect. We brought this to the attention of the interim manager immediately who arranged for the care plan to be updated.

Another person had a contracted hand. The occupational therapist had visited and provided a palm protector. They left written instructions that the person's hand needed washing daily and staff needed to monitor the thumb web space. However, this information was not put in a care plan and shared with staff. The person did not have their palm protector in for the duration of the inspection. The interim manager acknowledged that there was not a plan in place and that staff had been completing a record of arm exercises that the person was no longer doing. This person's care needs had not been planned for and delivered. This placed them at risk of further damage to their contracted hand.

We saw that two other people with contracted hands did not have palm protectors in that had been provided by an occupational therapist. The interim manager acknowledged they also did not have care plans in place for this.

We saw and records showed a third person who was living with dementia could become unsettled and often wanted to leave the home. Their care plan stated that they should be offered daily walks, weather permitting. We checked their daily records and found this had not happened on a consistent basis. For example for the week of the inspection, records showed the person was attempting to leave the home at times but staff did not take them out as directed by their plan.

Following the last inspection another person living with dementia had left the home unaccompanied and had been taken to another place of safety by a member of the public. Staff told us they monitored this person every half an hour to make sure they knew of their whereabouts at all times. They were knowledgeable about how to occupy the person when they were unsettled and wanted to leave the home. They told us this included going out for walks and this was included in their care plan. We reviewed the records and the person had not been taken out for a walk as detailed in their care plan even when the records detailed they were unsettled. In addition, the person's care plan did not include that staff needed to monitor the whereabouts of the person half hourly. At 10.23 am the half hour monitoring records for the final day of inspection had not been completed since 08.00 am. This meant the person's care plan did not include all of the information staff needed, the plans were not being followed and the records for one day did not accurately reflect where the person was for over two hours.

At our last inspection in July 2015, we found one person's teeth and dentures had not been cleaned as directed in their care plan. At this inspection we checked this person's records and they did not include whether dental care had been provided. In addition on the final day of inspection their dentures were in a dry pot and were not soaked in denture cleaning tablets as detailed in their oral care plan. Their records did not include whether they had received dental care.

A second person's teeth were stained and covered in food debris on two days of the inspection. Staff told us they brushed the person's teeth daily but the staining could not be removed. We checked the person's tooth brushes and they were caked in toothpaste and one brush had a hair in it. The toothpaste also did not have a lid. Their records did not include whether they had their teeth cleaned.

A third person's dentures were in a dry pot and they did not have any toothpaste or denture cleaning tablets. Their care plan included they needed their teeth cleaned twice a day and that they needed their upper denture in during the day. They did not have their dentures in when eating. Their records did not include whether they had received dental care. Following the inspection we were told the person had not

worn their dentures for a number of months but their care plan had not been updated.

As identified in the 'effective' section of this report, a fourth person's dentures had been missing since July/August 2015. No action had been taken from July/August 2015 until November 2015 to contact a dentist. Although records showed that from November 2015 staff had periodically reviewed whether the person was registered with a dentist they were not registered until January 2016. The person told us they had a sore and painful mouth and had lost weight. The dentist visited on the second day of inspection and staff put in a plan of care and treatment following the advice of the dentist.

A relative raised concerns that their family member, a fifth person, had not seen the dentist since moving into the home. The relative said they had provided the home with the contact details of the person's private dentist but this had not been followed up. They said, "(person) used to be so meticulous about her teeth". Staff at the home confirmed this person had not seen the dentist.

We saw two people who were in bed in their bedrooms had some stimulation such as the radio or they had a plastic slinky to hold. However, this was not consistent. There was little or no stimulation for some people cared for or staying in their bedrooms for long periods of time. For example, one person who was not able to reposition themselves had nothing to look at, no music or anything to touch or hold. Another person had previously in July 2015 had their bed positioned so they could see out of their bedroom window. At this inspection their bed had been moved and was positioned against the wall facing away from the window. The bedroom walls did not have anything on them for the person to look at and they had nothing to listen to, hold or do whilst they were in bed.

Some people in the lounges were occupied by colouring or looking at magazines and newspapers. We observed some group activities such as ball games and interactive smelling oils being provided by care workers and one of the cooks. There were some large games, puzzles, and soft toys available in the main lounges but these were not personalised to people or based on their interests. We did not observe people independently picking up these items.

An experienced activities worker had recently been appointed who worked two days a week. They were working one of the days of the inspection. People's moods and faces visibly lifted when this person entered the lounges. They provided personalised activities for people. For example, one person said they wanted to do something to thank the staff and the activities worker provided them with support and materials to make a card. People living with the later stages of dementia had hand massages and soft touch.

One relative told us they were concerned about the lack of activities and stimulation for their family member now because they were spending more time in their bedroom.

These shortfalls in people's personal and emotional care, stimulation and support needs being fully planned for and delivered were a repeated breach of Regulation 9 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in July 2015 we identified people did not have access to their call bells. At this inspection people had access to their call bells. Two people told us staff responded promptly but one person said the lack of staff had made an impact on how quickly staff responded to the call bell.

The provider's action plan submitted to us included that there was a daily check completed to make sure people who could use them had access to their call bells. However, the interim manager confirmed there was not any daily monitoring system to make sure people had their call bells or any audits of the call bells to

assess how quickly staff responded. This meant the information provided in the provider's action plan was incorrect.

At our inspection in July 2015 we found the shortfalls in the complaints systems were a breach of the regulations.

At this inspection relatives we spoke with knew how to raise concerns and told us they would speak with one of the directors, interim manager or the deputy manager.

The complaints information was not displayed. In addition, the information about how and who people could complain to in their contract with the home was incorrect. We reviewed the complaints records, the complaints procedure and the information sent to us in the provider's action plan and PIR.

The numbers of complaints recorded in the home differed to the information submitted in the PIR for the last 12 months. There were three more complaints or incidents recorded in the home's records. There was not a consistent way of recording complaints, they were not reviewed, complainants were not consistently responded to and learning was not shared with staff to minimise the risks of reoccurrence. There was only one complaint that was investigated in line with the complaints procedure and that was completed by the previous manager who left in January 2016.

The shortfalls in the complaints systems were a repeated breach of Regulation 16 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service well-led?

## Our findings

The home was still not well-led. At the July 2015 inspection there were no clear management arrangements in place at the home in the absence of the registered manager, to assess and monitor the quality of care and any risks to service users.

Following the inspection the registered manager who is one of the directors of the provider cancelled their registration as manager. Management consultants were appointed to operate and oversee the home. Another manager was appointed in September 2015 and applied to be registered with CQC and they were successful following their interview in November 2015. However, they chose not to be registered this manager left the home in January 2016.

On the second day of this inspection the management consultant appointed by the provider told us they did not have the autonomy to fully manage the services. This was because the provider continued to appoint and manage staff, have a day to day presence in the home and managed the home. For example, the providers had appointed a prospective service manager following the departure of the previous manager without consulting or involving the management consultants.

The management consultant's contract was annulled by the provider during the inspection and new management consultants were appointed and were present in the home on the last day of the inspection. This meant the assurances given to us by the director of the provider in meetings and in management contracts about the management consultants being fully allowed to manage the services were not accurate.

One of the directors of the provider continued to be actively involved in the day to day management of the home. We saw minutes of staff meetings that had been attended by and one meeting was arranged by the director of the provider. This contradicted the information given to us by the director of the providers about them not being involved in the management of the home.

The interim manager told us surveys had been handed out to relatives in December 2015. The comments we saw were positive, however, only one of the surveys were dated. This meant we and the interim manager were unable to establish whether they had been returned during this survey period or during a previous period prior to our last inspection.

We saw there was a recent compliment letter from a relative. The interim manager told us they shared this with staff at handovers.

A relative raised concerns with us about the way the directors of the provider managed staff at the home. They said had observed the directors, "Telling staff off" and that this had resulted in a number of staff being upset. They told us they were concerned that staff would not remain working at the home. They told us this would have a negative impact on their family member because the staff knew them well.

Relatives gave us mixed responses as to how well they were consulted and kept involved with important matters. This contradicted the information the provider submitted to us in their monthly action plans. For example, the provider's December 2015 and January 2016 action plans stated that following the negative press reports about the July 2015 inspection report, they had, 'contacted all the relatives to reassure them that following the report, dated back in June/July this year, we have since made progress in all areas'. We were also told by the management consultant that the deputy manager had telephoned all of the relatives. In addition, in a safeguarding meeting we had discussed with the provider and management consultants the need to communicate with all people and their relatives the findings of the inspection and the action plans they had put in place. However, a visiting relative told us they had been very concerned about the press coverage but they had not had any contact from the staff at the home to reassure them or give any update as to what they were doing about it. They told us there had not been any relative or representative meetings held or communication with them regarding the last inspection report.

Two relatives and one person raised concerns about the laundry at the home. They said clothing went missing and was damaged. Two relatives told us they now washed their family member's clothes themselves after repeatedly raising concerns but there being no improvement.

A 'Residents Meeting' had been held in January 2016.The meeting was chaired by the interim manager, twelve people and one of the cooks and one of the directors attended. The meeting was used to consult with people about activities and food. People who attended gave their feedback and action plan was made in response. We saw some actions were being completed. For example, staff were offering snacks to people who were not mobile but other actions had not yet been completed. However, the meeting minutes showed people were not given any information or updates about the management arrangements at the home following the departure of the previous manager or any updates on actions that were being taken to drive improvements at the home. The minutes were not available for people who did not attend the meeting. It was not clear how else the staff and managers at the home were involving or consulting with people.

Staff knew what the current management structure was at the home and who they reported to. They told us the interim manager had held a staff meeting following the departure of the previous manager. The interim manager and staff told us information was shared with staff at handovers each morning and evening. However the interim manager told us this information was not recorded and they did not have staff communication record.  Staff meetings had been held with the staff on duty during the inspection to feedback the concerns identified and what actions were being taken in response.

Staff knew how to whistleblow and the interim manager was able to give an example of when staff had reported concerns about a colleague. They said action was taken and the staff member no longer worked at the home. However, we were not given any copies of this incident when we requested copies of all the incidents.

We were given contradictory information by the provider, management consultants and the interim manager. As detailed in throughout report the information submitted in the PIR, the monthly action plans, safeguarding meeting minutes differed to our findings during the inspection. For example, we requested information during the inspection about the names and numbers of staff that had left or were dismissed from the home. We compared this against the rotas from the July 2015 inspection, information given at safeguarding meetings in September 2015 and the PIR and the information given did not include all of the staff that had either left the service or had been dismissed.

The provider told us in their PIR they had updated their statement of purpose and this was available in alternative formats including different languages and with pictures. They gave us a copy of this document

that was dated October 2015 but this had been updated in January 2016 to reflect the deputy manager as interim manager. This document included some incorrect information such as the interim manager's qualifications, making complaints to CQC, the name of the home, and the contract for people made multiple references to Highfield Manor Care Home and another care home operated by the directors. This meant it was not clear which of the care homes the contract related to. The statement of purpose was not available in alternative formats when we requested this.

We reviewed the systems in place to assess, monitor and review the quality and safety of the service. We were provided with a copy of the quality assurance policy. This policy was not being followed or had not been fully implemented. In addition, the provider told us in their monthly action plans and PIR that they were developing audits that would feed into action plans. However, these had not been fully implemented at the time of inspection. For example, incidents, accidents, falls and complaints had not been reviewed or analysed to see if there were any patterns, or to identify how any learning could be shared with staff.

There was not any accurate audit or reviewing systems in place that fed in to an improvement plan for the home. The findings throughout the inspection showed there was a failure to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk. In addition, there was a failure to assess, monitor and improve the quality and safety of the services provided.

Overall record keeping about people had improved. However, two other people's whereabouts was being monitored every half an hour because of the risks of them attempting to leave the home. One person's was only completed hourly not half hourly and on the second day of inspection at 11.20 am the record had not been completed since the 9am to 10am slot. The person was no longer in their bedroom or corridor as the last record showed. For the other person, one of these half hourly monitoring records were not completed for over two hours during one day of the inspection. This meant if the people went missing staff would not have known when they were last seen. Another person's records included a daily physiotherapy exercise record for staff to complete. This had been completed by staff on a daily basis but the interim manager told us these records were not correct because this person was no longer doing these exercises. We checked the person's care plan and the person had been discharged from the physiotherapist. These shortfalls in record keeping meant there was not an accurate contemporaneous record for each person at the home.

The interim manager, deputy manager and directors of the provider took action when we identified shortfalls throughout the inspection. However, they had not identified these shortfalls themselves. The action plans and PIR they submitted to us were not an accurate reflection of the quality assurance systems in place at the home. This meant there continued to be serious shortfalls in the governance and assessing the safety and quality of the service provided to people. The provider has not consistently achieved or sustained compliance with the regulations since October 2014.

These shortfalls in the governance, management of risks, record keeping, acting on feedback from relevant persons and the lack of improvement planning were a repeated breach of Regulation 17 (1)(2)(a)(b)(c)(e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The CQC rating for the home was not displayed nor was there a copy of the inspection report available for people and visitors to see. Failure to display the home's inspection rating was a breach of Regulation 20A (1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had not been notified of all the safeguarding allegations and investigations as required by the regulations. In addition one person had been discharged from hospital with a pressure sore and we were not notified about this. These shortfalls in making notification to CQC were a breach of Regulation 18 of the

Care Quality Commission (Registration) Regulations 2009.

The interim manager told us they were proud of the improvement in the quality of care provided to people by the staff. They personally felt more confident about being open and transparent. They told us they had felt very well supported by the previous manager and that directors were now letting them manage this service. However, as reflected in this report this was not the experience of all the staff and relatives we spoke with.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments<br><br>Failure to display the home's inspection rating was a breach of Regulation 20A (1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

Fixed Penalty Notice