Ark Care Services Limited

Highermead Care Home

Inspection report

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Date of inspection visit:
12 June 2018

Date of publication:
17 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Highermead Care Home on 12 June 2018. Highermead is a 'care home' that provides care for a maximum of 22 adults. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the inspection there were 11 people living at the service.

The service is on three floors with access to the upper floors via stairs or a passenger lift. At the time of our inspection only the ground floor of the building was in use. Shared living areas included two lounges, a dining room, an activities room and gardens with a patio seating area.

Highermead Care Home is owned and operated by Ark Care Service Limited. This company is based in London and also operates a second registered care home in Preston, Lancashire.

Prior to this inspection Highermead Care Home had been inspected five times since October 2016. At all of these inspections issues were identified in relation to the quality of care and support provided at the service. The service was rated Inadequate in October 2016 and Requires Improvement at each of the other inspections. The reports of all previous inspections are available on the Care Quality Commission website. These reports show that although the service had made some improvements in response to inspection findings these improvements had not been sustained. During our April 2018 inspection we identified concerns in relation the service's staffing arrangements. As a result, we asked the provider to give us details each week of the service's staffing arrangements. This information was provided.

On the day before this inspection the local authority informed people, their relatives and the service that they were no longer willing to commission care from Highermead. People were offered support to identify and move to alternate care placements during the week of our inspection. The provider chose to close the service on Friday, 15 June 2018 as at that time no one was living in the service. The provider has subsequently applied for this location to be removed from there registration.

At this inspection we again rated the service Requires Improvement. Risk assessments and care plans did not provided staff with appropriate guidance on how to support people whose behaviour could put them or others at risk. In addition, where incidents had occurred within the service they had not been documented or appropriately reported to senior staff for further investigation. Although accidents had been recorded there was limited evidence these had been investigated to identify any changes that could be made to improve safety in the service.

During our previous inspection we found that the service was understaffed but that all planned care shifts had been covered using staff overtime, management cover and agency staff. At this inspection we again found that the service did not employ sufficient staff to cover planned care shifts. There was a particular shortage of night staff and records showed that in the four weeks prior to this inspection only 56% of night

shifts had been completed by staff employed by the service. The remaining night shifts had been completed by a staff member from the provider's other service in Preston, Lancashire or by agency staff.

The service aimed to have three staff on duty during the day but we found the service had been short staffed on three occasions since our last inspection. In addition, we noted that the service's domestic cleaner had been unavailable for a number of shifts. On the day of our inspection there was no domestic staff on duty and no domestic cleaning tasks were completed. Some areas of the home appeared unclean and malodours were found in areas throughout the service.

The service did not currently employ any dedicated activities staff and on the day of our inspection people were not supported to engage with meaningful activities. On two occasions people approached staff to enquire about activities but none were provided. There was a board listing activities planned for the week which included an exercise class. Staff told us the information was not accurate and one staff member commented, "There is not much going on at the moment". We did not observe staff providing any individual or group activities during our inspection and there was limited evidence available to demonstrate the service's activities room had been recently used. One person had been identified as being at risk of social isolation and their care records highlighted to staff the importance of spending time with this person on a one to one basis. However, there were no records to show this support had been provided.

The service is required to have a registered manager. 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.

There was no registered manager in post at this inspection. The acting manager had resigned and withdrawn the application to register following our previous inspection in April 2018. This was the second occasion since 2016 when an acting manager at Highermead had withdrawn from the registration process.

The provider's nominated individual was now managing the service directly and had been based in the service since the acting manager's departure. Staff told us they had felt well supported by the nominated individual during this period and told us, "[The nominated individual] has been here the whole time, she is approachable." However, there was a clear lack of leadership and oversight in the service on the day of our inspection. There were no domestic staff on duty and no arrangements had been made to allocate other staff to complete these tasks.

Records showed the nominated individual had not appropriately led by example while covering care shifts. No detailed records of the care provided to people in bed had been completed during a night shift covered by the nominated individual. This meant it was not possible for the service to demonstrate people's care needs had been met.

In addition, the service's quality assurance systems were ineffective as they had failed to ensure compliance with the legislation. Important information in relation to how staff should support individuals was missing from their care records and incidents had not been documented and recorded. Senior staff were unaware of significant incidents that had occurred within the service.

Prior to this inspection significant concerns were raised with CQC about recruitment practices within the service. As a result we reviewed the recruitment records available for 11 staff including all staff employed in 2018. We found the service had operated safe recruitment practices and that all necessary pre-employment checks had been completed. Staff records also showed appropriate training and supervision had been

provided.

At this inspection we found people medicines were now managed safely. Creams had been dated on opening and accurate records maintained in relation to medicine that required stricter controls.

People were comfortable in their surroundings and told us, "The staff are great, lovely nice people." While relatives said, "The staff are really good with [My relative] they can always calm him down" and professionals told us the staff knew people well. Staff responded quickly to people's care needs and people told us, "Staff come when I ring the call bell."

Following our inspection the provider made a decision to submit an application to cancel their registration of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not entirely safe. Incidents and accidents had not been appropriately recorded or investigated to identify any changes necessary to ensure people's safety.

The service was short staffed and some planned care shifts had not been provided.

Recruitment procedures were safe and staff understood local procedures for the reporting of suspected abuse.

People's medicines were managed safely as prescribed.

People's medicines were managed safely as prescribed.

People's medicines were managed safely as prescribed.

Is the service effective?

Good

The service was effective. Staff were sufficiently skilled to meet people's needs and had received regular supervision.

People's nutritional and hydration needs had been met and fresh fruit and vegetable were available within the service.

People's choices were respected and staff understood the requirements of the Mental Capacity Act.

Is the service caring?

Good

The service was caring. Staff knew people well and provided support with compassion.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not responsive. There were no dedicated activities staff and people had not been supported to engage with meaningful activities.

People's care records had been regularly updated but lacked

information on how to support people while upset or anxious.

Care records had not been fully completed by the nominated individual while covering night shifts.

There was a complaints systems in place and concerns raised had been investigated.

Is the service well-led?

Requires Improvement

The service was not well led. There was no registered manger in post. The acting manager had withdrawn from the process of becoming a registered manager and left the service prior to this inspection.

Quality assurance systems were inappropriate as they had failed to ensure the service complied with the regulations.

Records had not been accurately maintained.

Staff felt well supported by the provider who had been based in the service since the acting manager departure.

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Highermead 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.

The inspection was prompted in part by information Care Quality Commission received following an incident when a person using the service was alleged to have been harmed. Information available at the service in relation to this incident was reviewed as part of this inspection process

This inspection took place on 12 June 2018 and was unannounced. The inspection team consisted of three Adult Social Care inspectors.

A previous focused inspection of this service was completed in April 2018 when the service was rated as Requires Improvement. During that inspection two breaches of regulations were identified.

Before this inspection we reviewed information we held about the service, previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with four people, three relatives, six members of care staff, the provider's nominated individual and a health professional who regularly visited the service. In addition, we observed staff supporting people throughout the home and during the lunchtime meal. Some people at the service were living with dementia so we used our Short Observational Framework for Inspection (SOFI) to record details of people's experiences of care. We also inspected a range of records. These included, three care plans, 11 staff files, training records, staff duty rotas, meeting minutes and the service's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in April 2018 we found the service was in breach of the regulations. Damaged linoleum flooring which presented a trip hazard had not been replaced, incidents had not been appropriately investigated and a boundary fence had not been repaired following an incident where a person fell into an adjacent field having left the service without support from staff.

At this inspection we found the damaged linoleum flooring had been replaced. In addition faulty stair gates had been repaired so they now locked securely. However, the damaged boundary fence had not yet been repaired. The work was planned and the necessary materials had been ordered. In the week following the inspection the provider advised us the fence had been repaired.

At this inspection we again found that accidents and incidents had not been appropriately recorded or investigated to identify how safety issues could be resolved. For example, a relative told us of a recent incident where their family member had been physically restrained to ensure other people's safety. However, there were no incident records available in relation to this use of restraint. We reviewed this person's daily care records and found a number of significant incidents had occurred. These incidents had not been reported to the management team for further investigation. When staff were asked about the reported use of restraint they described three recent incidents involving this person where it had been necessary for them to take action to ensure people's safety. No incident records had been completed in relation to any of these incidents. We reviewed this person's care plan and found no specific risk assessments had been completed in relation to these known behaviours. Although staff described techniques they had previously used successfully to support this individual this information was not available within the person's care plan. This meant staff did not have specific guidance on how to support the person when they were at risk of hurting themselves or others.

In another person's care plan we found a body map detailing a number of bruises that had been found on the person's hand and arms. No records were available of any investigation having been completed into how these bruises had been sustained.

In addition, the service was required to maintain accurate details of sexualised behaviour and language as a condition of one person's authorisation under the Deprivation of Liberty Safeguards. Daily records showed this person had been found asleep in another person's bed during a night shift. This had not been investigated as an incident and it was not possible to establish from the information available if the bed had been occupied by anyone else at the time of this incident.

One person's care plans stated that they were on line of site observations. This was because the person had been identified as being at risk if they left the service without support from staff. During our inspection we found staff had not maintained the required observations of this person. However, staff did report that they were completing half hourly checks of the service's external doors to ensure the alarm system was operational.

Accident book records had been completed for some accidents that had occurred within the service. However, there was limited evidence these accidents had been investigated or reviewed by senior staff to identify any learning or changes that could be made within the service to improve safety.

This meant the service remained in breach of the requirement of Regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because incidents had not been reported or appropriately investigated and necessary risk assessments had not been completed.

The provider had identified staffing levels that were necessary to meet people's needs. These were three members of care staff during the day and two staff at night. At our last inspection we found that although the service was short staffed these planned staffing levels had been achieved. Records showed some staff had worked excessive hours and the acting manager had regularly been providing hands on care to ensure planned staffing levels were achieved.

At this inspection we again found that the service was under staffed with a particular shortage of night staff. On the night prior to the inspection the service had been staffed by an experienced carer from the provider's Preston service and a member of agency staff. Staffing records showed that all planned night shifts had been covered in the four weeks prior to the inspection. However only 56 % had been provided by staff employed by the service. This meant people were regularly being supported at night by staff with limited experience of working in the service. In addition, during the first May bank holiday weekend the service had been critically short staffed due to unexpected illness. In order to ensure people's safety the nominated individual had travelled from London to cover two care shifts as agency staff had not been available.

Staff told us, "In the last month it was high agency but it has settled down", "Any gaps in the rota are covered" and "I'm not going to lie it hasn't been easy. It feels on the up now with so many new staff starting."

Following concerns about staffing levels identified during our April 2018 inspection we asked the provider to give us details each week of the service's staffing arrangements. From this information in the five weeks prior to this inspection we found that on one day the service had been understaffed all day and on two further occasions the service had been short staffed in the evening from 17:00 to 20:00. Records showed that agency support had been requested to cover these gaps in the rota but had not been available. Staff rotas showed that, in order to achieve planned staffing levels, some staff had again worked excessive hours, that agency staff had been used regularly and that both the acting manager and the nominated individual had covered care shifts. Although planned staffing levels had generally been achieved, the use of management resources to cover care staff shortages had impacted on both the acting manager's and provider's ability to focus on their leadership roles.

Personal protective equipment was readily available to staff who responded promptly to manage infection control risks during this inspection. However, we noted during our analysis of staffing arrangements that a significant number of domestic cleaning shifts had not been covered. On the day of our inspection there were no cleaning staff on duty and we did not observe care staff completing domestic cleaning tasks. We found that areas of the home appeared unclean and there were malodours in areas throughout the building.

The service did not employ sufficient numbers of staff to meet people's care needs. This meant the service was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative told us, "There is a high turnover of staff as well, so no continuation for residents." Staff rotas

showed there had been significant number of personnel changes since our last inspection. The nominated individual recognised that the service was under staffed and was actively recruiting additional care staff at the time of this inspection. Records showed five new staff had been appointed since our previous inspection. In addition, staff told us "We have four new staff waiting for either references or references and DBS checks. This will bring it up to over staffed." The nominated individual confirmed four additional staff had been appointed but were awaiting recruitment checks.

Prior to our inspection, concerns were reported that a staff member had been employed at Highermead before necessary recruitment checks were completed. As a result of these concerns we reviewed the recruitment records of 11 members of staff including all staff recruited in 2018. We found all necessary pre-employment checks had been completed. Interview records showed employment gaps had been explored and references had been checked. The service had requested enhanced Disclosure and Barring Service (DBS) checks for all staff employed. These included Adults First checks designed to enable service's experiencing staffing shortages to quickly confirm that prospective staff are not barred from working with adults. The service had subsequently identified concerns about one new member of staff's practice during their initial care shifts. The provider had taken timely and appropriate action to address these concerns to help ensure people's safety.

People told us, "I feel safe, I like it here" and relatives said, "[My relative] would not be here if I was not happy with the place." Staff told us they were confident people were safe and commented, "If I wasn't I wouldn't work here" and "I believe people are safe here." Staff understood their role in protecting people from abuse and avoidable harm and records showed safety concerns had been appropriately raised with the local authority. Safeguarding contact details were displayed throughout the service and were readily available to people, visitors and staff .

At our previous inspection we identified recording failures in relation to the dating of creams and the documentation of controlled medicines which contributed to a breach of regulations. At this inspection we found these issues had been addressed. All medicinal creams were now dated on opening and accurate records had been maintained of when controlled medicines had been received and administered.

The service continued to used non-standard codes on Medicine Administration Record (MAR) charts but these codes were well understood by staff who were always available to support professionals while reviewing medicine records. This eliminated the risk of confusion or information being mis interpreted by visiting professionals.

All MAR charts had been fully completed and there were protocols in place detailing when and how "as required" medicines should be used. Medicines were stored appropriately and the temperature of the medicines fridge and medicine room had been monitored. People told us, "I get all my creams and that."

The service's fire fighting equipment had been regularly serviced and tested. All other necessary environmental safety checks had been completed as required by appropriately skilled external contractors.

Good

Is the service effective?

Our findings

People's needs and wishes were assessed before they moved into Highermead. These assessments were completed by senior members of staff to ensure the service could meet people's expectations.

The service had an induction system in place to ensure all new staff had a good understanding of the service's policies and procedures. Before their first shadow shift, new staff spent time in the service with senior staff reviewing policy documents, completing training the service considered mandatory and gaining an understanding of how the service operated. In addition, staff new to the care sector were supported and encouraged to complete the care certificate. This training package has been designed to provide all staff new to the care sector with an understanding of current good practice.

Staff told us they had initially shadowed experienced staff for, "at least three days" before providing support independently while the nominated individual stated that the service aimed to provide additional shadowing shifts for inexperienced staff and shift leaders. One recently appointed staff member told us, "I just shadowed the [Shift leader's name] for three shifts and I also shadowed the provider as well. I just watched, I did not do any personal care."

Analysis of staffing rosters in the five weeks before this inspection showed that the majority of staff had completed shadow shifts. However, we found that on one occasion a new staff member had not completed any shadow shifts before providing care. This member of night staff had started work during the first May bank holiday weekend. At this time the service had been particularly short staffed and the nominated individual had to cover two night shifts at short notice due to staff sickness and lack of available agency support. This meant an inexperienced staff member had been required to provide care without the benefit of having observed experienced staff practices.

Staff told us, "I get a lot of training" and records showed staff training had been regularly updated. Records showed that staff received training from a variety of sources including, on line training, in house training by suitably qualified senior staff and training provided by external professionals. Individual staff training records showed staff were sufficiently skilled to meet people's needs.

Staff said they felt well supported by the provider and had received regular supervision. Staff comments included "We get supervision every six months, last was about two months ago" and records showed staff had received regular one to one supervision. In addition, meetings had been held regularly to keep staff up to date with changes within the service and staff told us, "We had a staff meeting last week."

We observed the support people received during the lunchtime period. People had a choice of meals and staff were knowledgeable about people's likes, dislikes and dietary needs. The service's kitchen facilities were clean and there were appropriate quantities of fresh fruit, vegetables and other ingredients available. People told us, "Food is quite nice" and "I enjoy the food." Where people required a soft diet, individual menu items were processed separately so people could to continue to enjoy the individual flavours.

At our previous inspections in January and April 2018 we found that carpets in corridors were heavily stained and in need of replacement. In addition, in April we found that the service boundary fence was damaged. One person had become lost when they accessed the garden without support and had fallen into an adjacent field.

At this inspection we found the stained carpets had not been replaced and that the boundary fence had not been repaired. We discussed both these issues with the nominated individual who explained these works were planned for later in the week. Records demonstrated the building materials for the fence had been ordered and quotes sought for the replacement of the carpet. In the week following our inspection the provider advised us that the boundary fence had been repaired.

The service was decorated in an eclectic style and some doors had been individually decorated with a variety of wallpaper designs. Bathrooms, toilets and people's bedrooms were clearly identified to help people move around the service independently.

At our last inspection we found the service had appropriate systems in place to assess people's mental capacity in relation to specific decisions and that unnecessarily restrictive practices had been discontinued. However, we found best interest decisions had not been formally documented and made a recommendation in relation to this issue.

At this inspection we again found that people's capacity to make specific decisions had been assessed and documented in accordance with the requirements of the Mental Capacity Act. The Act 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. Where people lacked the mental capacity to make specific decision and choices the service had made appropriate decisions in the person's best interest. Where possible people's relatives and health professionals had been involved in decision making processes to ensure any decisions made were in the person's best interest.

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 service had identified that some people were unable to leave the service without support from staff and were thus deprived of their liberty. Appropriate applications had been made for the authorisation of these individuals restrictive care plans. Where additional restriction had been introduced as a result of changes to people's care needs this had been highlighted to the authorising authority.

Health professionals visited the service regularly and records showed the service had made prompt and appropriate referrals for additional support when changes in people's care needs were identified. Professionals told us the staff team were good at following any advice they provided to ensure people's needs were met.

The service had systems in place to record people's consent to their planned care. These records had been completed where people had the capacity make these decisions or where people had appointed representatives with lasting power of attorney in relation to health and welfare. When relatives informed the service they had been given lasting powers of attorney the appropriate documents had been viewed. Records were kept to help ensure staff were aware of the decisions relatives had the legal authority to make.

Staff protected people's privacy and ensured doors were closed while they were providing personal care. People were able to decline planned care. Staff told us they encouraged people to accept care when required and if declined would offer support at later time to ensure the person's needs were met.

Good

Is the service caring?

Our findings

We spent time in shared lounges and the dining room to observe how care was delivered and received. People were comfortable in their surroundings and approached staff for support or reassurance without hesitation. People told us, "The girls are brilliant" and "The staff are great, lovely nice people." Relatives said, "The staff are really good with [My relative] they can always calm him down."

Throughout our inspection we saw that staff treated people with respect and provided support with kindness and compassion. Professionals told us, "The staff seem to know a lot about people" Staff had a good understanding of people individual likes and preferences. One staff member commented, "We've had a lot of different staff in the past but this team is one of the best I've seen so far."

Staff responded promptly when people requested support and people told us, "Staff come when I ring the call bell." In bedrooms call bell systems were consistently positioned within people's reach. We found that in one bathroom the alarm cord could not have been used if a person fell to the floor. This issue was highlighted to staff and promptly resolved. One person became unwell during our inspection. Staff responded promptly and appropriately to this person's needs and provided assistance with care and compassion.

Staff protected and respected people's human rights and promoted individuality. Where people had expressed preferences in relation to the form of address used by staff information was recorded within the person's care plans and consistently followed by staff. For example, most people were referred to using the first name and one person was known by a nick name they enjoyed. However, another person preferred to be addressed more formally and staff respected this person's wishes.

People were able to make choices and decisions about both how their care was provided and where to spend their time. People chose what time they got up in the morning and when they went to bed and staff told us two people normally stayed up until the early hours of the morning. On the morning of our inspection two people were up when we arrived at the service at 07:45. One person said they normally liked to get up early while staff told us the other person had chosen to get up early that day.

People could bring their pets with them when they moved into the service and at the time of our inspection one person had their own cat and another person had some fish. Staff supported people to look after their pets and people enjoyed interacting with the cat in the service's shared areas.

Requires Improvement

Is the service responsive?

Our findings

The service did not have any dedicated activities staff and on the day of our inspection we saw no evidence of people being supported to engage with meaningful activities. One person's relative told us, "There used to be two girls here, who used to do activities, I bought lots of colouring pens and skittles, all sort of things. We paid for it all but nobody takes the time to use it." During the morning of our inspection one person asked a staff member what the plans were for the day. The staff member looked surprise to have been asked and replied, "We'll play it by ear shall we. Maybe do a crossword later?" We did not observe this person being supported to complete a crossword later in the day. On another occasion a different person approached a different member of staff and asked about whether there were any plans for the day. The staff member supported the person back to a chair in lounge advising them to have a, "nice relaxing day."

There was an activities board which listed a number of different activities planned for the week of our inspection including an exercise class. We asked staff about this and were told the information was not accurate. During our inspection most people spent their time in their room asleep or watching television. In the lounges some people spent their time listening to music or with the television on. One person chose to sit outside in the sunshine during the afternoon. We did not observe staff providing any individual or group activities during our inspection although we did see people enjoying the company of visitors. Staff told us, "We used to have entertainers in but not at the moment." They added, "There is not much going on at the moment".

There was a room adjacent to one of the lounges that had previously used for activities. There was limited evidence that it had been recently used to support people with crafts and the window display related to Easter.

One person's care plan identified that they were at risk of becoming socially isolated as they were cared for in bed. This person's care plan highlighted to staff the importance of spending time with this person on a one to one basis to provide companionship but there were no records to show this support had been provided.

The failure to support people to engage with meaningful activities is was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People care plans were generally up to date and provided staff with information and guidance to meet people's individual care needs. Staff were encouraged to support people to remain as independent as possible and care plans gave staff detailed information about the level of support normally required with specific tasks. For example, one person's care plan stated, "[Person's name] will wash his face and front of his body. One health care assistant to assist with washing and drying his back, legs and hair if required." Staff told us "They are better organised now than they were." However, we found there was a lack of guidance for staff on how to support individuals whose behaviour staff may have put others at risk as detailed in the safe section of this report.

Care plans included details of the support people needed with communication and to access information. Where people used hearing aids or glasses this was recorded in their care records and staff were provided with guidance on how people preferred to be supported with these aids.

Care plans had been developed from information supplied by commissioners, relatives and the person during the assessment process. This was combined with staff feedback on the person's individual needs during their initial period of support to form the basis of the person's care plan.

Information about people's life history, background and interests was included within the care plan to help staff recognise how the person's background could affect their current care needs. This information also helped new staff to identify topics of conversation the person was likely to enjoy.

Staff completed daily records of the care and support they provided. Where people were assessed as needing to have specific aspects of their care monitored, additional records were completed detailing the support people had received in bed. This included records to show when people were re-positioned, observations of their mood, details of their food and fluid intake and the care which staff had provided. These records were normally accurate and informative. However, the nominated individual had failed to document the care they had given while covering a night shift. This meant it was not possible to establish that necessary care had been provided during this period.

The service had a complaints policy in place and people and their relatives understood how to make complaints if necessary. On the day of our inspection the nominated individual was in the process of investigating a concern that had been recently raised by a family member. This concern was being investigated and the nominated individual had approached the relative to gather additional specific information and provide initial feedback on the matters raised.

There were systems in place to record details of people preferences in relation to their care at the end of their lives. Records showed the service had worked with community health professionals to support people to remain in the service and be comfortable at the end of their lives. Where people had chosen not to be resuscitated this information was appropriately recorded and readily available for emergency responders.

Requires Improvement

Is the service well-led?

Our findings

Highermead Care Home is owned and operated by Ark Care Service Limited. This company is based in London and also operates a second registered care home in Preston, Lancashire.

Since October 2016 Highermead Care Home has consistently failed to comply with the requirements of the regulations. The service has been inspected five times previously during the last two years. It had been rated Inadequate in October 2018 and was rated Requires Improvement overall at the remaining four inspections. The reports of these inspections are available on the Care Quality Commission website and show that, although some improvements had been made they had not been sustained.

At this inspection we have again rated the service Requires Improvement and identified breaches of regulations in relation to staffing levels, incident recording and the lack of activities within the service. These issues are similar to concerns that have been reported on previously. This demonstrated the service's quality assurance systems required further improvement as they had again failed to ensure the service complied with the requirements of the legislation.

Prior to this inspection the local authority made the decision they were no longer willing to commission care from Highermead Care Home. This had been explained to the people, their relatives and the provider on the day before this inspection. People had been offered support from the local authority to identify alternative care placements. Social workers were on site throughout most of the day of the inspection supporting staff from other care services to complete assessments of people's needs. All eleven people living at Highermead were subsequently supported to move to other care services and the provider chose to close the service on Friday, 15 June 2018.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had not had a registered manager for over a year.

At our pervious inspection in April 2018 there was an acting manager in post who was in the process of applying for registration. Following that inspection, the acting manager withdrew their application to become registered and gave notice of their intention to resign. This was the second occasion since 2016 when an acting manager at Highermead Care Home had withdrawn from the registration process. This meant that the service had not had stable management arrangements.

At this inspection we found the acting manager had left the service. There was no registered manager in post and the provider's nominated individual was now managing the service directly. It was clear from comments received from staff during this inspection that there had been a significant breakdown in communication between the provider and the acting manager in the period since the last inspection.

Since the acting managers decision to resign, the nominated individual had met regularly with staff to give them additional support and reassurance. Staff told us they felt well supported by the nominated individual during this period. Their comments included, "Morale is much better since certain staff left", "We feel supported, there have been times when we haven't" and "[The nominated individual] has been here the whole time, she is approachable." However, there was a clear lack of leadership and oversight in the service on the day of our inspection. There were no domestic staff on duty and no arrangements had been made to allocate other staff to complete these tasks.

Records showed the provider's nominated individual did not appropriately lead by example while covering care shifts. We found that while covering two night shifts the nominated individual had failed to fully document the care they had provided. This meant it was not possible for the service to demonstrate people's care needs had been met during these care shifts.

The service's records had not been appropriately maintained. Significant information in relation to how staff should support individuals was missing from their care records and incidents had not been documented and recorded. These failures meant senior staff were unaware of significant incidents that had occurred. These incidents had not been investigated to identify any learning or changes that could be made to improve safety within the service.

This meant the service was again in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to operate effective systems and take the action necessary to ensure compliance with the regulations.

Although the provider had replaced damaged flooring to address safety concerns following our last inspection other necessary works including the replacement of stained carpets and repairs to the service's boundary fence had not been completed. Documents showed these works were planned and that contractors had been appointed. In the week following this inspection the provider advised us the boundary fence had been repaired.

During previous inspections staff had raised concerns in relation to the lack of investment in the service by the provider. These issues were discussed with the nominated individual at this inspection who recognised there had been delays in making some investments. They explained they had been unable to invest previously as there had been significant delays in payments from care commissioners.

The nominated individual was open and cooperative throughout the inspection process and staff told us, "[The nominated individual] is willing to take on ways to improve" and "[The nominated individual] is open to suggestions as well and has taken ideas on board." However, following our inspection the provider made a decision to submit an application to cancel their registration of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they had failed to support people to engage in meaning full activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service remained in breach of the requirement of Regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because incidents had not been reported or appropriately investigated and necessary risk assessments had not been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems had not ensured compliance with the regulations and records had not been accurately maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service was in breach of regulation 18 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as planned care and domestic staff shifts had not been completed.