Ark Care Services Limited

Highermead Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 12 July 2017 and was unannounced.

Highermead Care Home is a care home which provides accommodation for up to 22 older people who require personal care. At the time of the inspection 13 people were using the service. Some of the people who lived at the service needed care and support due to dementia, sensory and /or physical disabilities.

At the time of the inspection, there was no registered manager in post. A new manager had been appointed who was about to undertake their induction. The owner told us this manager would seek to become the registered manager of the service. 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.

We previously inspected the service on 7 February 2017. Prior to that inspection, this service had been placed in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During the inspection on 7 February 2017 the service demonstrated to us that improvements had been made and it was no longer rated as inadequate overall or in any of the key questions. Therefore, this service was no longer in special measures. At that time, the overall rating of the service was requires improvement. The service was also meeting the requirements of the previous regulatory breaches. At this inspection, we found that improvements in some areas had been sustained however, a number of issues previously identified had not been resolved.

People's rights were not always protected as the principles of the Mental Capacity Act were not always followed. Some people's records contained out of date or irrelevant capacity assessments and some capacity assessments had been left blank. Where people were considered to lack capacity, we saw no evidence of best interest processes to ensure that decisions taken on their behalf were the least restrictive available, or in the person's best interests. The previous registered manager had submitted applications to the supervisory body for authorisation under the deprivation of liberty safeguards (DoLS) however, in the absence of a best interest process, we could not be assured that the restrictions set out in these documents were the least restrictive available. We saw examples where friends and relatives had signed documents to consent to elements of people's care and treatment without the legal authority to do so.

We found people's end of life care plans were not detailed. Many of them directed staff to speak to the person's next of kin. This placed people at risk of not receiving care in the way they had chosen at the end of their life.

We found the home was visibly clean and free from adverse odours. There was an on-going programme of refurbishment. We saw that murals and paintings had been added to the walls in several areas of the home

and the outdoor courtyard was now in use. We noted that the carpet in the downstairs corridors remained heavily stained. We found some concerns with the environment, for example some COSHH (care of substances hazardous to health) items such as disinfectant were left in an unlocked bathroom throughout the day. People had personal emergency evacuation plans (PEEPS) in place, but these did not contain a photograph of the person. This might mean emergency staff could not identify the person in the event of an emergency if they were not in their bedroom. We noted that the sluice room was not lockable. We also found that the CQC rating was not displayed at the service as required.

People's medicines were not always safely managed. Practices and recording around the use of covert medication (medicine which is disguised in food or drink) were not robust. We saw some discrepancies on people's medication administration charts (MAR). We found that the storage and disposal of people's medicines was generally safe.

Not all staff we spoke with had received appropriate training. One person who was new to care had been in post several months and had not undertaken the Care Certificate, or a suitable alternative. The care certificate is a national set of standards for people who work in the care sector. We found some gaps in staff member's mandatory training. Some staff had not received recent supervision, however all staff we spoke with told us the owner was approachable and supportive should they require help or assistance. Recruitment practices were generally safe; however we found one staff file where references were not sought appropriately and where there was no record of the person's DBS check (disclosure and barring service). We were provided with this information following the inspection. The person had a DBS in place which had been undertaken at another place of employment, but the check had been made too long ago to ensure it was robust.

People had access to activities on a daily basis, provided by housekeeping staff. However these were basic and not person centred. We have made a recommendation about this. There were visitors to the service such as singers and petting animals, however these were infrequent.

People had access to a range of health and social care professionals and this was reflected in their care records. Where people's needs changed staff promptly sought the assistance and advice of external agencies. During the inspection, we saw health professionals visiting the service. Care plans had been reviewed and updated and contained guidance for staff on meeting people's needs. However, some of the assessment tools were not reflective of people's changes in need.

Mealtimes were sociable and relaxed with staff on hand to provide assistance as required. The food on offer looked plentiful and appetising and people were offered second helpings. The cook was aware of people's dietary requirements. People were encouraged and assisted to have enough to drink during the day. There was a snack station which people could obtain items such as fruit, chocolate and yoghurt from.

People who used the service were protected from the risks of abuse. Staff knew how to recognise and report signs of abuse, including which external agencies they should alert. Alerts had been made to the local authority and care Quality Commission when required.

On the day of the inspection, we observed sufficient staff on duty to meet people's needs in an unhurried way. Staff had time to sit and chat with people and engage them in activities. We were told that periods of short staffing were managed through the use of agency staff and that new staff had now been recruited to fill some of the vacancies. Staff were caring and we observed positive interactions between people and staff in which they were treated with kindness and respect.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not always safe.

People's medicines were not always managed safely. Covert practices and recordings were not robust and there were discrepancies on medicine administration records (MAR).

Potentially hazardous substances and areas of the home were not always secure.

Recruitment practices were not always robust enough to ensure that staff were suitable to work with vulnerable people.

People were protected by staff who understood how to recognise and report signs of abuse or mistreatment.

Is the service effective?

Requires Improvement

Aspects of the service were not always effective.

People's rights were not always protected because the principles of the mental Capacity Act (MCA) were not always followed.

People were not always supported by staff who had received an appropriate level of training.

People's health and social care needs were met through access to a range of professionals.

People were supported to have their health and dietary needs met.

Is the service caring?

Requires Improvement

Aspects of the service were not always entirely caring.

Issues in relation to the quality of end of life care planning raised at previous inspections had not been addressed.

Interactions between people and staff were compassionate and kind.

People were supported to maintain relationships with people who mattered to them. Relatives were treated with kindness and were made to feel welcome and valued.

People's confidential information was securely stored.

Is the service responsive?

Requires Improvement

Aspects of the service were not always responsive.

Some assessment tools in people's records required updating and were not always reflective of their needs.

Activities were taking place, but these remained basic and visitors from entertainers were infrequent.

People's care records were personalised and contained details about their background, history, likes and dislikes.

There was a process in place for receiving and investigation complaints.

Is the service well-led?

Requires Improvement

There was no registered manager in post, although a manager had recently been appointed and was due to commence their induction.

There was not an appropriate level of auditing, to monitor the quality of the service.

The CQC rating was not displayed at the service as is required.

Staff we spoke with were committed to delivering a good service.

The provider undertook regular visits to support staff.

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 checked 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 12 July 2017 and was unannounced. The inspection was undertaken by two adult social care inspectors.

Before visiting the service we reviewed information we kept about the service such as previous inspection reports and notifications of incidents. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern.

During the inspection we spoke with four people who lived at the service and observed others who could not always communicate verbally. We also spoke with one relative. In addition, we spoke with two visiting professionals and six members of staff, including the provider and domestic and kitchen staff.

During the inspection, we looked around the premises. We also undertook general observations as well as observing the lunchtime experience. We looked at six records associated with people's care. We looked at four staff files and training records for all staff. We looked at maintenance records, policies and procedures and a number of other documents associated with the running of the service.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely at the service. The storage and disposal of medicines was checked and found to be satisfactory, however we found examples where medicines had been given to the person but not signed for. The service was not undertaking medication audits which meant that errors might not be identified and learning from these errors might not take place. We also found that practices around covert medicines were not robust. Covert medication means medicine which is disguised in a person's food or drink. There had been a recent medication error where a person had been given food which contained someone's covert medicine. Although action had been taken following this incident to ensure that the person was safe and to reduce the likelihood of a future incident, there were still areas relating to covert medication which required improvement. For example, one person's doctor had agreed for them to have their medicines disguised in food, however there was no review date to ensure that this practice remained closely monitored and no evidence of a best interest process to ensure this was the least restrictive option available to the person. In addition, the agreement was not detailed, did not state which medicines should be covertly administered, how or under what circumstances. It appeared that the medicine was being given covertly each time without first offering it to the person.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found some concerns in relation to the safety of the environment. For example, some COSHH items (care of substances hazardous to health), such as disinfectant and cleaning products were kept in an unlocked bathroom. We also noted that there was no sign on the door of the sluice room to identify it and no lock on this door to ensure that it was not accessed by those using the service. There was also a dirty linen room which was not locked. In addition, we did not find any hand gel on the ground floor of the service, for example, for those entering or leaving the building. This might mean that opportunities to reduce the risk of cross infection were missed. However, the service was visibly clean and free from adverse odours throughout. People's bedrooms were clean and tidy and commodes were empty.

People had personal evacuation plans (PEEPS) in place, which detailed the level of support they would need to evacuate the building in the event of an emergency. However, these documents did not contain a photograph of the person. This meant that if the person was not in their bedroom at the time an emergency evacuation was required, it might not be possible for emergency staff to identify them.

Although recruitment practices were generally safe, we found concerns with two staff recruitment files we checked. One staff member's file did not contain references. We were told that this was a staff member who had been at the service for some time as agency and references had been checked by that agency. This was not robust and the service would need to undertake their own reference checks. We saw another example where the DBS check (disclosure barring service) was not documented on the staff member's file. After the inspection, we were provided with evidence from the provider that a DBS check had been undertaken, when the staff member was working for another service, however this was too long ago to ensure that it was a robust check that the person had not had any recent convictions. We discussed this with the provider and

they assured us it would be addressed.

Prior to our inspection we had received information of concern relating to staffing levels. On the day of the inspection, we saw that staffing levels were satisfactory. Staff were able to respond to people's needs in an unhurried way and to engage in activities with them. We routinely saw staff sitting with people, offering them support and sharing conversation and appropriate humour. We were also told that new staff had been recently recruited to fill some of the vacancies at the service. One staff member said; "Staffing isn't too bad. We have more staff coming on board now too".

People and their relatives told us the service was safe. People were protected by staff who knew how to recognise and report any signs of abuse or mistreatment, including which external agencies they should alert. Staff had received training in safeguarding adults and there was information on display around the service to advise staff of important contact numbers should they wish to make an alert.

There were regular checks to ensure the safety of the building. The boiler and gas appliances had been tested to ensure they were safe to use and portable electrical appliances had been tested. Equipment such as hoists had been tested and were satisfactory. There were weekly fire drills and alarm tests. Where issues had arisen with the building, such as a recent problem with the hot water, CQC had been notified and the service had taken prompt action to repair any damage.

Risk assessments were in place for each person. For example to prevent falls, pressure sores, and poor nutrition and hydration and these had been recently reviewed. Where risks had been identified these were linked to the person's care plan to provide guidance for staff on how to reduce the risk and help keep the person safe. One person had been identified as at risk of falls when queuing for the dining room. Their record guided staff to be vigilant at mealtimes, and to ensure walkways were clear.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. We looked at people's care records and saw examples where capacity assessments were either out of date, left blank or no longer relevant. For example, one person had a capacity assessment which was completed in 2015 relating to the decision to consent to respite care. This was no longer relevant as the person was a permanent resident at the service.

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. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Deprivation of Liberty Safeguard (DoLs) applications had been submitted to the local authority. However there was no evidence of best interest processes in relation to these applications and capacity assessments had not been completed or recorded. In the absence of a best interest process it was not possible to assess whether the person's care was the least restrictive option available, or in their best interest.

People's consent had not been appropriately recorded within their care records. We saw several examples were friends or relatives, without a Lasting Power of Attorney for welfare had signed to say they consented to elements of a person's care. Nobody can consent to an adult's care without a Lasting Power of Attorney (LPA). If there is no LPA, a documented best interest decision must be made in line with the principles of the MCA. This had been highlighted to the provider at the previous inspection in February 2017 who had said that this would be addressed and care records and practices would be amended to reflect this. We saw no evidence that this action had been taken.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's consent was routinely sought by staff throughout the day. For example, we saw staff at lunchtime asking people if they needed, or wanted help with eating or moving. Staff asked people for consent before covering them with an apron at meal times and asked their permission before changing the channel on the television or radio.

Staff had access to a programme of e-learning. Staff underwent training in a number of subjects identified by the provider as mandatory, such as safeguarding, infection control, fire safety and moving and handling. In addition, they had received training which was specific to their role such as dementia awareness and challenging behaviour awareness. One staff member was being supported to undertake a team leader course. We reviewed the staff training and found some staff were not up to date with training the provider considered mandatory such as food hygiene, infection control and Mental Capacity Act. We also noted that one member of staff who was new to care, but had been in post several months had not undertaken the

care certificate or equivalent. The care certificate is a nation set of standards for staff working in the care sector. The provider told us this would be addressed and said she had wanted the staff member to have some direct experience with people before undertaking the training.

Staff new to the service had received an induction which included shadowing more experienced staff members. One staff member we spoke with who was new in post confirmed that they had received their induction and that it was satisfactory. Not all staff we spoke with had received supervision or an annual appraisal. One staff member told us they had not had supervision in around two years. We reported this to the provider who said this would be addressed by the new manager. All staff we spoke with told us they felt well supported by the provider and able to seek guidance and advice from her as required. Staff also confirmed that they had; "job chats" with senior staff members. These were competency checks in which areas for improvement could be identified. Any recurrent concerns were being shared with the provider so that training needs could be identified and addressed.

There was an ongoing programme of refurbishment at the service. Since our last inspection, the enclosed, secure courtyard had been finished and people were able to access this area. There were raised flower beds in the garden in which one person living at the service had planted flowers. The provider told us that in the recent hot weather, people had sat in the gardens and enjoyed ice-creams. A staff member had painted pictures along the walls in the corridors and more brightly coloured murals and stickers had been added to the walls in the lounge and dining room. There were further plans to create a hairdressing salon, and some of the furniture for this had just arrived. We saw that some chairs had been removed from the lounge and were being replaced. The carpets in the corridors on the ground floor remained heavily stained. The provider told us these were going to be replaced.

The environment was dementia friendly with contrasting decoration along different corridors to help people orientate themselves. People had chosen the colour and decoration of their bedroom door to personalise it and make it easier to identify. Hand rails were brightly coloured to ensure they were easily visible. There was a whiteboard with important information written on it, such as the date, the weather outside, activities on offer and staff on duty that day. There was also a menu board which detailed the meal being served that day.

We observed the lunchtime experience. Most people chose to eat in the dining room. There were staff on duty to provide assistance to people if they required it. Music played in the background and the atmosphere was relaxed and pleasant. Staff made conversation with people and shared appropriate humour. People appeared comfortable with staff, engaged in conversation and shared jokes. The food appeared appetising and plentiful and people were offered second helpings. People told us they enjoyed the food. Comments included; "The food is pretty good" and "The food is very nice to eat and nicely presented". There was also a snack station which people could obtain items such as fruit, chocolate and yoghurt from between mealtimes.

People had access to a range of health and social care professionals such as community psychiatric nurses, dentists, speech and language therapists (SALT) and chiropodists. There were multi-disciplinary notes in people's records to document any advice or guidance for the staff. On the day of the inspection, we saw a visiting mobile dentist and a nurse both undertaking visits to the service.

Requires Improvement

Is the service caring?

Our findings

People had end of life care plans in place, however some of these were very basic. We saw one example where a person had a funeral plan in place, but other examples which directed staff to discuss people's end of life wishes with family or next of kin. This was identified as an issue and highlighted to the owner at the previous inspection in February 2017. It is important that staff are aware of people's end of life wishes in order that care provided is in line with their choices and preferences. In the event that a person experienced a sudden decline in their health or experienced an unexpected death, it may not be possible to consult with their relatives, meaning their care may not be delivered according to their wishes.

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

We saw one example, where an offer of care was made in a way which was not discreet. This related to a staff member assisting a person to use the toilet. This was reported to the provider who was disappointed and said that it would be discussed with staff. In the majority of interactions we observed that respected people privacy and dignity. If people were talking and staff needed to ask them something, they routinely said; "Sorry to interrupt". People's confidential information was securely stored at the service, in locked cabinets. The office was locked when not in use. We saw staff members knock and wait to be invited to enter before accessing people's bedrooms.

People told us the service was caring and staff were kind. Comments from people included; "I'm happy here"; "I enjoy myself here. They are very nice people" and "The staff are very, very good". One relative we spoke with said; Staff are very kind to [family member's name]. There were compliments cards on display in the entrance praising staff for the standard of care they provided. Comments from staff included; "Staff here are lovely" and "Everyone here is respectful and person centred".

Throughout the day we observed kind and caring interactions between people and staff. We also heard staff sharing appropriate humour, using words of encouragement and stopping to chat. We overheard a conversation between a person and a staff member, discussing a radio programme which was playing in the lounge. The radio programme was about a local place of interest. Both the staff member and the person had visited this place previously and were discussing their experiences of it.

Staff were mindful of people's comfort and wellbeing. Staff routinely asked people if everything was alright and if there was anything they needed. One staff member was heard to say to a person; "Are you feeling cold? Shall I go and get you a cardigan to wear?" later on, a different staff member asked another person; "It's warm in here and your cheeks look pink. Do you want a hand taking off your cardigan to cool you down?" Staff offered people drinks and refreshments frequently throughout the day. We saw copies of the day's local newspaper on people's tables. We saw one staff member helping a person with their crossword.

Staff took an interest in what people were doing. One staff member was heard to say; "What is that you are reading? Looks interesting". One person had expressed an interest in keeping fish. In response a fish tank had been purchased and was kept in the lounge, containing goldfish. Staff were heard to use this as a

talking point with the person.

People were encouraged to maintain their independence wherever possible. One person's care records stated; "When washing [person's name] hair, let her do as much for herself as she can!" Another staff member was playing skittles in the lounge with a person. The person was heard to say; "Oh I won't be able to do that". The staff member responded by saying encouragingly; "Yes you can! I know you can do it".

Staff spoke about the people they cared for with fondness and affection. People were spoken to using their preferred name and this was detailed in their care records. People's records evidenced that they had access to advocacy services. We saw letters from advocates in people's records and saw that they had been invited to attend people's care reviews.

Care plans we inspected contained information to assist staff to understand people's needs, likes and dislikes. This information had been reviewed and updated as required. Relatives were involved with care planning where possible and this was reflected in the care records. Staff knew the people they cared for well. They were able to tell us about their preferences, background and history. People confirmed that they were able to get up, and retire to bed at the time of their choosing. One person's care record stated; "[Person's name] likes to go to bed at around 10:30pm, but she likes to sit in the lounge in her nightie from 8pm onwards". One person we spoke with confirmed; "You don't have to be up too early and you go to bed when you're ready"

Requires Improvement

Is the service responsive?

Our findings

People had a personalised activity plan in place which detailed their interests. There was also a daily activity sheet for each person, which listed activities they had taken part in. Activities were provided for an hour each day by the housekeeping staff. On the day of the inspection, we saw people being offered to play skittles in the lounge. Some people joined in. Others declined the offer. One person commented that the activity was for children. The activities on offer were limited and included; board games, film afternoons, skittles and bingo. There were some ad-hoc pampering sessions where staff would paint people's nails. Staff told us that the nail bar which had been created at the time of our last inspection was not used often as people did not like to go into a different room to have their nails painted or manicures. There were limited opportunities for trips out, although staff hoped this would improve.

We recommend that the provider research more personalised and imaginative activities to offer people living at the service.

There were occasional visits from outside entertainers such as petting animals and a singer. A fun day was being organised which was to be open to the public. Plans included hiring a bouncy castle, so that staff and the public could bring their children and encourage integration between people living at Highermead with younger generations. We were told that there had been a recent; "Ice-cream party" during the hot weather, Where people sat outside in the garden eating ice-cream and enjoying the sunshine.

People's care records contained detailed, personalised information. This included details of their background likes, dislikes, childhood and previous occupation. There were photographs of the person at different times in their life. This helped staff to understand the person and was a useful conversation starter. People's relatives had been involved in gathering this information. People's care plans were detailed documents which provided guidance for staff on how to meet their needs in the way they preferred.

Care plans were detailed documents which were regularly reviewed and updated with involvement from people's families where appropriate. Care staff we spoke with confirmed that records contained the correct level of guidance for them to meet people's needs. Care staff completed comprehensive daily logs detailing people's activities and wellbeing throughout the day and night.

Staff responded promptly to any changes in people's needs. One person had been experiencing episodes of agitation and staff had contacted district nursing staff to undertake a review. Advice on how to care for this person during these episodes had been sought and staff were following this advice. Another person had changed and become more withdrawn, referrals had been made to external agencies to query if the person was experiencing cognitive changes or mental ill-health. One external health care professional we spoke with confirmed that the service sought their advice when required.

Where people's needs had changed, new equipment had been purchased to ensure their needs continued to be met. For example, high-low beds had been ordered for two people who had experienced recent falls from bed a new easy clean flooring had been ordered for one person who experienced frequent periods of

incontinence to ensure their bedroom remained hygienic and smelled pleasant. There was a daily handover book, to inform staff of any changes which had occurred during their shift.

Relatives were made to feel welcome at the service and there were no restrictions on visiting times. We saw relatives visiting people throughout our inspection and being treated respectfully by staff. One relative we spoke with confirmed; "They are kind to us here. They will always contact us if there are any problems".

There was a system in place for receiving, investigating and managing complaints. This practice was underpinned by a complaints policy. Staff and relatives we spoke with said they would feel confident to raise a complaint and felt it would be dealt with to their satisfaction.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was not a registered manager in post. A new manager had been appointed and was due to commence their induction imminently. The provider was hopeful that this manager would seek registration with the Care Quality Commission and provide the leadership required to sustain improvements and raise standards at Highermead. At this inspection, it was not possible to make a judgement about this.

In the absence of a registered manager, the provider told us they had been spending alternate weeks at the service, undertaking some managerial duties and assisting and supporting staff. Staff members spoke very highly of the provider. Comments included; "When [provider's name] is here I'm a lot happier"; "[Provider's name] is just fantastic" ; "She always tells me, if I need any support, just call me"; "[Provider's name] is very nice and very capable" and "[Provider's name] is very friendly and cares about staff. She is firm but reasonable".

In the absence of a registered manager, audits to monitor the quality of the service were not being undertaken adequately. We only saw one example of an environmental audit undertaken by the provider. Audits are important in monitoring the way the service is being delivered, identifying any areas of concern and raising standards. Due to a lack of effective auditing opportunities to identify and address areas of concern, such as those we found with Mental Capacity Act compliance, medication management and staff training had been missed. The provider told us that there were plans to introduce audits and checks in a number of areas such as cream charts, MAR charts, food diaries and care plans, however this was yet to begin.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted at the time of the inspection that the CQC rating was not displayed at the service. The provider must ensure that the most recent CQC rating is displayed on at least one sign at the location. This is important as it informs the public of the provider's performance at the service. This was highlighted to the provider who said it would be immediately addressed.

This was a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that there had not been a quality assurance survey for over a year. This meant that an important opportunity to gain feedback on the service had been missed. We were told that there was a survey last year, but that the results were not available on the day of the inspection. The service was not currently holding residents' or relatives' meetings. But there was a plan for these to commence.

There were regular staff meetings at the service which enabled staff to meet as a group, share ideas and discuss any concerns they had. Staff we spoke with told us they felt confident in raising concerns with the

provider and felt ideas and suggestions would be taken on board.

The provider was committed to forming links with the local community. A fun day was being arranged which was to be open to the public. The purpose was to raise awareness of the service and increase integration between people living there and the people in their local community. A staff member told us it was hoped that people would bring their children, as spending time around children and young people raised the spirits of those living at Highermead.

Staff we spoke with during the inspection were committed to their role and to raising standards at the service. One staff member told us they felt things had continued to improve. The staff member said; "We are definitely on the up".

The service had an up to date whistleblowing policy, which supported staff to question practice. It clearly defined how staff raising concerns would be protected. Staff confirmed they felt able to raise concerns and felt confident the management would act on them appropriately.

The Care Quality Commission (CQC) had received notifications as appropriate when there were any concerns regarding people's well-being or safety. There were clear procedures in place for making safeguarding alerts to both CQC and the local authority. This demonstrated an open and transparent approach to sharing information with other agencies where required.

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 End of life care plans were not sufficiently detailed. This meant people were at risk of not receiving care in the way they wished at the end of their life.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental Capacity assessments were often left blank, out of date or no longer relevant. Friends and family members had signed to consent to elements of people's care without the correct legal authority to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely. Covert medication practices were not robust. We found errors on Medication Administration records (MAR). There was not an effective auditing system in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was not an effective auditing process in place to monitor the quality of the service and to raise standards.

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 The latest CQC rating was not displayed at the service as required.