Babbacombe Care Limited

Hadleigh Court

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?	**Inadequate**

Overall summary

This inspection took place over two days on the 8 and 13 October 2015. The first day of the inspection was unannounced and took place at 6am to enable us to meet with the night staff and see people being supported in the early morning. The second day was announced. The inspection was bought forward due to concerns shared with the Care Quality Commission (CQC). At the time of the inspection the concerns were being investigated by the local authority safeguarding team.

Hadleigh Court is a long established care home providing care and accommodation for up to 31 people. 28 people were living at the home at the time of the inspection.

Most of the people living at the service were older people, many of whom were living with a significant dementia, some of whom were also physically frail. Some people were younger and living with long term health conditions.

There was a registered manager in post at the service at the time of the inspection. 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.

Summary of findings

We identified concerns about a lack of leadership and effective governance of the home. This meant systems had not been put in place to ensure people's care could be delivered effectively and safely. Changes in people's needs were not being identified and medical and professional advice was not always being sought at an early enough stage to prevent ill health or deterioration in people's condition. Where people were having falls or other accidents action was not taken to analyse the incident and take actions to help prevent them happening again. This meant care was not always safe.

Records kept were not fit for purpose; many were out of date and there were no audits of practice being carried out to enable the provider to judge the quality of the services provided or take action to address shortfalls. Notifications had not been sent to CQC as required by law. Care plans were not personalised to each individual and did not contain sufficient detailed information to assist staff to provide care in a manner that was safe and respected people's wishes. Medicines were not always being stored safely, although staff understood how people should be given their medicines and people told us that they received the medicines they needed at the right time.

Staff did not always have the skills, training or support they needed to do their job, and there were not always enough staff available to help people get the care they wanted when they wanted it. This meant sometimes care was task based rather than being based on people's wishes and preferences. Staff recruitment practices were not robust, which meant that people could have been placed at risk by being cared for by staff who could be unsuitable. Concerns were expressed by agencies supporting the home that their recommendations were not being implemented consistently to improve people's care.

Concerns raised were not always being fully investigated or addressed robustly and safeguarding practice including staff training in how to protect people was not up to date. Staff understood how people expressed their wishes and consent, but had not received training in how to protect people's rights under the Mental Capacity Act 2005.

The design of the premises did not reflect best practice in dementia care, but improvements were being made, both to the building and to support better control of infection and improve cleanliness. However, risks presented by the premises had not been audited or managed properly and the premises had not always been properly adapted to meet people's changing needs.

We saw many examples of positive and supportive care being delivered from staff, but we also saw instances where staff did not recognise that people's needs were not being met, or care did not respect people's dignity. Staff respected people's confidentiality and celebrated successes and special events with people, and the home had a good programme of activities for people to follow which were provided one to one or in groups. People told us they enjoyed their meals and people's dietary needs were respected.

People told us they were happy at the home. People's relatives were positive about the care their relation received. They told us they felt involved with people's care and were free to visit at any time.

Where concerns were identified to the provider at this inspection we saw they were quick to take action to make improvements.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We have made a recommendation about sufficient staff being available to support person centred care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The home was not always safe.

Risks to people were not always being assessed. When people's needs changed people were not always having their needs and risks re-assessed or concerns escalated which meant care was not always safe. However people told us they felt safe.

Risks from falls and accidents were not being analysed to help assess how they could be prevented again. Some risk assessments in relation to the premises were not up to date.

Concerns raised were not always being fully investigated or addressed and safeguarding practices including staff training were not up to date.

There were not always enough staff to deliver person centred care, and staff recruitment practices did not evidence a robust process was being followed to ensure staff were suitable to be working with people.

Medicines were not being stored securely, but people told us they received their medicines on time. The provider was taking action to address infection control concerns and improve the cleanliness of the premises.

Is the service effective?

Requires improvement 

The service was not always effective.

Staff had not all received the training they needed, and staff supervision and appraisal systems were not in place.

The principles and implementation of the Mental capacity act 2005 (MCA) were not well understood or put into practice.

The design of the premises did not reflect best practice in dementia care, but improvements were being made.

People enjoyed their meals and people's dietary needs were respected.

Is the service caring?

Requires improvement 

The home was not always caring.

We saw many examples of positive and supportive care being delivered.

However we also saw instances where people were not supported in ways that respected their dignity or privacy, or did not reflect a caring attitude from staff.

Staff respected people's confidentiality and celebrated successes and special events with people.

Summary of findings

Is the service responsive?

Requires improvement

The home was not always responsive.

Care plans were not always personalised to each individual and did not contain sufficient detailed information to assist staff to provide care in a manner that was safe and respected people's wishes. Care was not always being delivered in a person centred way, but was sometimes based on routines.

The home had a good programme of activities for people to follow which were provided one to one or in groups.

Complaints processes were not well recorded, or robust actions taken to address concerns, including those from staff.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager and nominated individual had not ensured that there were effective systems for governance, quality assurance or safe care for people.

The home's management did not demonstrate good leadership. There was no clear ethos for the service. Actions being taken to make improvements were in response to concerns identified by other agencies.

Records were not fit for purpose; many were out of date and there were no audits of practice being carried out to enable the provider to judge the quality of the services provided or take action to address shortfalls.

Notifications had not been sent to CQC or other agencies as required by law.

Hadleigh Court

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 was 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 8 and 13 October 2015. The first day of the inspection was unannounced and started at 6am to enable us to meet with the night staff and see people being supported in the early morning. The second inspection day was announced. The first inspection visit was carried out by an adult social care inspector and an Expert by Experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service. For this inspection the Expert by Experience was a person who has experience of supporting a relative living with dementia. The second visit was carried out by one adult social care inspector.

We looked at the information we held about the home before the inspection visit. We received information of concern from the safeguarding team about investigations that were being carried out at the home, and their findings.

We also received information from the local authority quality monitoring team about the work they were carrying out at the home to support improvements, including audits of training and medicines.

We spent time observing the care and support people received, including staff supporting people with their moving and transferring and being given medicines. We spent two short periods of time carrying out a SOFI observation. SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care. On the inspection we also spoke with ten of the 26 people who lived at the home, five visitors, and seven members of both day and night staff. We spoke with the staff about their role and the people they were supporting. We also spoke with a visiting Occupational Therapist (OT), and continence nurse advisor. The registered manager and Nominated Individual (NI) from the provider organisation were present on both days of the inspection.

We looked at the care plans, records and daily notes for five people with a range of needs, and looked at other policies and procedures in relation to the operation of the home, such as the safeguarding and complaints policies. We looked at five staff files to check that the home was operating a full recruitment procedure, and also looked at their training and supervision records. We looked at the accommodation provided for people and risk assessments for the premises, as well as for individuals receiving care and staff providing it.

Requires improvement

Is the service safe?

Our findings

The service was not always safe. We identified concerns in relation to safeguarding processes and the failure to escalate concerns; concerns in relation to how risks to people's health and welfare were responded to and managed; management of medicines; staffing levels in the early morning; staff recruitment practices and infection control. The nominated individual took action during the inspection that helped help reduce risks to people.

Concerns had been expressed by the local authority safeguarding team prior to the inspection regarding risk assessments and the monitoring of falls at the home. The local authority had supported the home by writing new assessments for people to identify risks such as for moving and positioning practices and put in place strategies to manage and reduce the risks. We saw these in people's files. They told us they had done this because the measures the home had taken were not adequate to keep people safe. These updated assessments had led to changes in the equipment used to help some people to move. For example one person was now being moved with a hoist rather than a stand aid, because previous practice being carried out by the home was no longer safe to meet their changing needs. Staff from the local Care Trust had also needed to visit the home to support staff to understand and follow the action plans for moving and handling people safely. Although we did not identify specific concerns on the inspection about the way people were being supported, staff from the Trust told us staff were still not always following the guidance they had been given to keep people safe. Care Trust staff were continuing to support the care home staff support people safely.

Patterns of falls were not routinely being analysed to see if there were changes that could be made to prevent a re-occurrence. There was no system to ensure that concerns over people falling were escalated to other agencies. Where people were falling staff were completing accident forms, and filing them in individual care planning files. There was no system for the management review and oversight of falls, and no clear guidance on obtaining medical advice. For example, one person's file contained thirteen falls related accident forms from the 25 July 2015 to the 25 September 2015. Some of these falls had resulted in injuries to the person, including skin tears and in one instance a fractured bone. This had not been reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) or to CQC. As well as being a legal requirement, these systems help alert agencies and the home to any further actions that might need to be taken to help prevent a re-occurrence of the incident.

Some actions had been taken to address safety concerns for people. We saw one person had moved their room, to ensure they were more accessible to staff in case they fell. A pressure pad had been provided to alert staff to the person being out of their bed in their room and being at risk of falling, as the person would not be able to use a call bell themselves to alert staff. However staff had not carried out a risk assessment of the possible hazards within the room taking into account the person's deteriorating health and high risk of falls. We viewed the person's room with the registered manager and found some large items of furniture were not stable or secured effectively to the wall. This meant if the person had fallen against them they could have toppled over onto them. Furnishings were not arranged in ways that minimised risks and hard corners or surfaces were not being protected to help reduce the risk of injury.

Although staff had contacted the GP or district nurse service when some people had fallen, they had not done this in the majority of instances. This meant on many occasions staff were making decisions on whether the person had sustained an injury without reference to appropriate medical advice. On the night before the first inspection visit one person had suffered a significant fall. Staff had made a decision the person had not sustained significant injury without reference to medical advice.

Another person had been subject to a number of falls. They told us "I've had lots of falls here, so I've not been out recently… I can't reach the bell sometimes so I just shout". On the second day of the inspection we saw this person and another had been provided with a new mobile pendant alarm to help them summon assistance in case of falling. They told us they were very pleased with this, as it gave them re-assurance they could get help if it was needed.

Investigations by the safeguarding team had identified people who were at risk of or who had deteriorating pressure ulcers. They told us concerns over people's skin integrity had not always been escalated early enough to prevent deterioration in people's health. One person had

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Is the service safe?

developed a significant pressure ulcer, at a Grade 4. This had not been reported to the CQC as required by law. The registered manager acknowledged the home had not always identified at an early stage that people's needs were deteriorating. For example, one person's file indicated district nurses had been called in as an emergency call to address concerns over a person's skin breakdown, which might have been prevented with earlier intervention. District nurses were still managing this at the time of the inspection.

We saw where people were at risk of choking their files contained assessments for the management of risks. For example one person needed a "fork mashable" textured diet. We saw this had been provided for them and spoke to staff who understood the importance of this for the person. Information about their needs was kept with them and was available in their room.

People living at the home told us they felt safe there. One person said "I feel well looked after, it's a good place for me to be…much better than where I was before". Relatives were positive about the home, one describing it as "Homely and safe". Another person told us that they had found "No cause for concern here. This is a lovely home for people and the staff are great".

We found other risk assessments, for example for the environment were not safe or up to date. We saw environmental risk assessments had been written in October 2010, and noted as having been updated annually since that time. However the risk assessments were not an accurate reflection of the risks at the service. For example, we saw the risk assessment for hot surfaces told us heated surfaces, radiators, pipes and panel convectors should not exceed 43 degrees centigrade, and that risks could be reduced by guarding heated areas. Radiator covers had been provided for the central heating system to prevent people coming into contact with hot surfaces. However, the majority of the rooms we visited also had small electric oil filled radiators, which were not secured and did not have their hot surfaces assessed or protected. These were not mentioned in the risk assessment. They were removed on the day of the inspection.

The failure to assess the risks to the health and safety of people is a breach of Regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to do all that is reasonable practicable to mitigate the risks to people is a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to have effective systems to ensure the safety of the premises is a breach of regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two members of staff we spoke with told us they had been shown how the fire system operated and were clear about what to do in the case of a fire alarm sounding. Fire equipment was being serviced regularly, and escape routes were clearly marked. One route had a fitted keypad, but we were informed this was automatically disabled if the fire alarms sounded. Arrangements to manage emergencies were in place and well understood. People had individual evacuation plans on display in their rooms and care files. Contact numbers were available for staff in case of emergencies, and staff told us they had used them when needed. There was a system in place to alert the handyman to minor maintenance issues, which were signed off when completed.

A recruitment process was in place that was designed to identify concerns or risks when employing new staff. We sampled five staff files, and identified concerns with all of the files. Certain risks had not been identified or addressed by the recruitment process, and some records were missing from the file, for example, references had not always been sought from the staff member's previous employer. It is a requirement of legislation that prior to employment the registered person gains satisfactory evidence of the 'staff member's conduct' in any previous employment in health or social care and of the reasons why they had left. Some files did not provide evidence of a full employment history without gaps in people's employment history being explored. Another file did not include exploration about whey the person had left their previous employment.

Three people's pre-employment checks had identified a potential risk. The registered manager told us they had discussed the concerns with the people concerned and considered the risk would not affect their employment. We could not see written evidence the registered manager had reviewed or assessed the risks, and the registered manager told us they had not recorded this. The registered manager told us they would discuss any risks about an individual's employment with the nominated individual. However we identified two files where this had not happened. The registered manager confirmed that they had not done this, and the nominated individual told us they had not been

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Is the service safe?

made aware of the risks. The home's policy on recruitment states gaps in employment history would be explored and that all those involved in the recruitment process "have been suitably trained to identify and assess the relevance and circumstances of offences". The policy was out of date and had not been put into practice. This meant people had not been protected by systems designed to ensure staff were suitable and safe to be providing care. The nominated individual has informed us that they will be taking responsibility and oversight of the recruitment at the home and will be carrying out retrospective checks.

The failure to follow a robust recruitment process is a breach of Regulation 19 (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014. The nominated individual has informed us they will be taking responsibility and oversight of the recruitment at the home.

At the time of the inspection seven people were under individual safeguarding processes at the home. This meant that the local authority was investigating concerns about their well-being and care. Staff demonstrated a good understanding of when and how to raise concerns about people. However the systems to support staff were not robust, and staff had not all received training in how to recognise and report abuse. Staff we spoke with told us that they would raise concerns if they were worried. One told us "You haven't got a choice – it's not about being comfortable, you have to do it". Policies and procedures were available to remind staff of what actions to follow in case of concerns in the home's safeguarding and whistleblowing policies, although these needed updating. Since the inspection the nominated individual has held meetings with the staff to

re-enforce that concerns should always be raised.

Where concerns had been identified about staff performance the registered manager had not followed the home's disciplinary policy and had not robustly investigated the concerns although we heard evidence that they had discussed issues with the staff members concerned. Where concerns were being managed by the nominated individual disciplinary actions had been taken to protect people at the home and ensure an investigation was carried out.

On the first day of the inspection some areas of the home were not clean and we identified issues with the management of infection risks. Where people had an identified infection control risk the registered manager told us there would be an individual infection control risk assessment and management plan in their file. We identified one person who had been discharged from hospital with an identified risk which had now been resolved. We could not find any records to demonstrate that a management plan or assessment had been undertaken.

The registered manager confirmed there were no systems in place for the audit of infection control at the home. We identified concerns in relation to the management of laundry systems, cleanliness and odour control in some rooms and the lack of staff handwashing facilities in the staff toilets. In addition, bathrooms and toilets had bottles of antibacterial hand wash which could present risks to people with dementia if accidentally ingested.

Once these concerns were identified, by the day of the second inspection visit the provider had taken immediate action to improve the safety within the home. The registered manager had contacted the Trust infection control nurse who visited the home to offer them advice on the management of infection risks and help with an auditing tool. New wall mounted dispensers had been fitted in all bed rooms and bathrooms, and sinks fitted to the staff toilets to enable them to wash their hands. A new system for the storage and management of laundry had been planned, that meant there could be separation of clean and dirty linens, and a new sink was being installed in this area. While we were at the home a new bed was delivered for one person where we had identified concerns over the management of urinary incontinence. Further discussions were held later in the day with the continence advisor about how to support the person concerned with their continence and the control of cleanliness and odour in their room.

People were not always supported by sufficient numbers of skilled staff on duty. The home was busy and active, and there was a significant number of people who had high care needs. There were enough staff on duty to identify and meet people's needs in a timely way in the day. However, in the early morning we found staff were pressured, and care was not being delivered in a person centred way. The nominated individual and registered manager told us they were recruiting for an additional person to cover these hours and had made changes to the staff rota, so that some staff came in earlier to support people.

Requires improvement

Is the service safe?

We recommend that the service puts in place systems to ensure that there are sufficient staff on duty at all times to ensure people's care needs can be met in accordance with their individual wishes.

People were not always being protected against the risks associated with medicines. No audits of medicines had been carried out, the home's policies and procedures were out of date and some medicines were not being stored securely. For example we found some prescribed creams were left out in people's rooms, and the medicines refrigerator in the kitchen was not locked. In one person's room accessible on a chest of drawers we found a container of a prescribed powder, which is used to thicken fluids to support people with swallowing difficulties. This could present significant risks to people if accidentally ingested. This was immediately removed to be out of reach of people. In the medicine cupboard we saw that some medicines had been prescribed for a person believed to be at the end of their life. The person had improved and the medicines were no longer needed. We saw that the bag containing the medicines had been opened and the contents recorded in the controlled drugs book. The registered manager agreed that the bag should be returned to the pharmacy for safe destruction.

The failure to manage medicines safely was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were in place to ensure people were given the correct medicines at the correct time. We observed two members of staff giving people their medicines, and saw they were given their medicines with sufficient time and explanations to help them understand what they were taking. Staff understood how the systems for the safe administration and recording of medicines worked and told us they had received appropriate training. Information for staff about how to use people's medicines was clear, for example there were body maps indicating where creams should be applied available in people's rooms. People told us they were given their medicines on time.

Requires improvement

Is the service effective?

Our findings

The service was not always effective. Staff had not all received the training they needed, and staff supervision and appraisal systems were not in place. The principles and implementation of the Mental Capacity Act 2005 (MCA) were not well understood or put into practice. The design of the premises did not reflect best practice in dementia care, but improvements were being made.

Prior to the inspection we had received concerns about the training and competency of the staff at the home. Staff we spoke with told us they felt competent to care for people, however, we found that the staff had not all been supported to undertake the training they needed to fulfil their role.

The home had identified some training as mandatory for their staff. However there was no system in place to ensure that staff all received this training. For example we saw from the home's training matrix that no staff had received training in falls prevention and only two staff out of 25 on the training matrix we were given had received training in Health and safety. We identified two night staff who worked together had not received fire awareness training. Only 28% of staff had undertaken training in food hygiene. By the second day of the inspection training courses had been booked for staff in this area, and support was being provided by the Trust and Skills for Care to access additional training for staff.

Regular staff were being supported by agency workers on both days of the inspection. We observed the agency staff leading and directing care, demonstrating to the permanent staff how care should be delivered, in particular in relation to supporting and positioning people and using equipment. Where we identified good care practice from staff on many occasions it was not the home's permanent staff that were delivering this. For example when we saw people being supported to eat the agency staff were spending individual time with the person, engaging them with the task and talking to them throughout. We saw one permanent member of care staff sitting at the table supporting two people to eat at the same time. This told us the standards of training and oversight of the permanent staff were not in accordance with best practice.

Training delivered was not based on a training needs analysis reflecting the needs of the people at the home. For example no-one was identified as having received training in supporting people with behaviours that might be challenging despite people at the home having those needs at times. Most staff had not received training in the Mental Capacity Act 2005. We saw a staff member supporting a person who was distressed, which they did well. We asked them how they had understood how to support the person in this way. They told us they had not received any training in dementia care, but had learned what worked for this person by spending time with them. Staff did not receive individual skills appraisals or performance monitoring. There were no learning plans in place. Staff training when it had been delivered had not been reviewed to see if learning outcomes had been met or what changes had taken place as a result of the learning. Other learning from training had not always been effective in developing practice. For example the registered manager and staff had attended a course in supporting people with dementia care and as a result had developed a 'memory corner', with items to stimulate people's memory of past times and belongings. We did not see people engaging with or being directed towards this space, which did not seem used or well understood.

Staff did not receive regular supervision. We saw in one staff member's file for example that they had not received supervision since 2012. The manager confirmed that supervision had 'lapsed' but told us they had daily contact with the staff at handovers and during the day. They also told us they were intending to carry out more spot checks on staff throughout the day and night to see that care plans and instructions were being carried out. However during the inspection an Occupational therapist (OT) identified a practice to the manager that the management team were not aware of. This told us that the management team were not having effective oversight of the care delivery or of how staff were working to support people.

The failure to ensure staff receive appropriate training, supervision and appraisal to enable them to carry out their duties is a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always having their rights protected because there was not a clear understanding of the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make specific decisions, at a certain time. When people are assessed as

Is the service effective?

not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. We did not identify specific concerns over people's care in relation to decision making; but we found the care planning process did not include good information about people and their decision making capacity, which would have made care planning more effective. People's capacity was not being clearly assessed and recorded in relation to areas of decision making. Where people lacked the capacity to consent to medicines for example there was no record of best interest decisions being made in relation to the administration.

Staff were respecting of people's consent to care, and we saw them speaking with people and involving them in what was going on while they were being supported. Staff were able to show and tell us how individuals who were not able to communicate their wishes verbally would indicate their dislike of a procedure. Staff told us they would then withdraw and try to persuade the person again later.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The registered manager was familiar with the Deprivation of Liberty Safeguards and applications had been made for authorisations to deprive people of their liberty which were under consideration by the local authority. Whilst some people were able to leave the home, others would not have been considered safe to do so unescorted and the main door to the home was locked with a keypad. This meant that people would not be able to leave without staff support or other assistance.

Hadleigh Court is a long established care home in a residential area of Torquay. Some corridors are narrow and some rooms not large, although characterful. We toured the accommodation with the registered manager, looking at how well the accommodation was adapted to meet people's needs. During the inspection we saw changes were being made to the accommodation to respond to concerns that had been highlighted. For example one person with a long term health condition was being consulted about changes to an en-suite facility as it had been identified they could not access the sink to brush their teeth due to the shape of the room. They told us they were very pleased that changes were being made which would help increase their independence. Light fittings over beds were being replaced with flush fittings that were safer for people.

The nominated individual and registered manager were aware of some best practice in term of environmental design and furnishings in supporting people with dementia, and were taking steps to improve the environment. For example in the last year highly patterned carpets had been replaced with plain carpets, and sensory objects such as textured cushions had been provided. Toilet doors had pictorial signs to let people know what the room was. However there were no directional or other information signs to support people in finding their way to the toilet or where to find drinks. In the central lounge area there were ceiling mounted fans which as it became dark made rapidly flickering patterns on the ceiling that could be disturbing or confusing for people with dementia.

People told us they enjoyed the meals served to them. People received a balanced diet and where people were at risk of poor nutrition or hydration there were risk assessments in their files. Some people were on fluid and food monitoring charts and these had been completed to demonstrate the amounts of fluid taken. The continence nurse advisor planned additional training for staff in the completion of these charts while we were at the home.

People who needed their food provided in softened or pureed forms had these provided. People who needed support to eat were given this, and people at risk of malnutrition were weighed regularly. We saw one person's file where they had been assessed as being at risk. Their records indicated they had now started gaining weight, which indicated that the measures being taken were effective. However, we did not see people being offered a choice of the meals and there were no tools to support communication with people who may have difficulties verbalising choices. There was no menu on display to let people know in advance what the meal was on offer. People told us their dietary requirements were respected, for example one person who was a vegetarian had a lasagne for lunch which they really enjoyed. They told us "I'm a vegetarian and they do me special food. Yesterday it was a (vegetarian) cottage pie which was really nice…. I don't like sandwiches in the evening so I have a jacket

Requires improvement

Is the service effective?

potato or something". Another person said "I don't like meat much, so if I can get to the kitchen and ask whats for lunch I can get the cook to do me an omelette or something".

Prior to the inspection we had received concerns that people were not receiving the healthcare support they needed. This was in particular in relation to the escalation of concerns about people's changing needs regarding moving and positioning and pressure area care. The registered manager told us that "lessons had been learned" and that access to healthcare would be sought promptly. We saw people had access to home based services like podiatry, and people's files contained evidence of access to GPs, district nurses, speech and language services and hospital appointments. People we spoke with told us they received the medical care they needed.

Requires improvement

Is the service caring?

Our findings

We identified concerns in the way in which people were being supported by staff that did not demonstrate a caring approach or an understanding of people's care needs.

Although people said they were supported by kind and caring staff, we identified concerns people's dignity was not always being respected, and staff were not always thinking about the impact of the way they were supporting people had on their well-being. For example, during the inspection it was identified that some staff were managing one person's continence needs on someone else's bed because it was more convenient than taking the person to their own room to do this. The practice did not demonstrate respect or privacy for the individual whose room it was or respect for the person being supported.

We did not see that care was always delivered in accordance with people's care plans or wishes, and so was not 'person centred' but based on routines and tasks that needed to be done. During the inspection we saw people were being got up early in the morning from around 6:15 am. Staff told us they had been instructed to do this by the registered manager as there were so many people that needed to be got up. People were then left in the dining room to wait without a cup of tea or their breakfast being given until staff were ready to do so. Some people waited for over 1 1/2 hours. Staff told us they were 'too busy' to get people a cup of tea at that time, but if they had time they would do so. New staff came on duty and saw people sitting in the dining room and walked past them without acknowledging them or getting them a drink. One member of staff who was not yet on duty came and sat in the dining room and ate a bowl of cereal in front of people before starting to get people a drink or their breakfast. Some people sitting in the dining room were becoming distressed and agitated. One person said "I don't like sitting here. I want my breakfast" and another person said "What's the point of all this? I'll go back to bed I think." People told us they did not want to be got up at that time and their care plans did not reflect that this was their wish.

The failure to treat people with dignity and respect was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to provide care in accordance with people's wishes and in a person centred way was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were able to have visitors at any time. Most people who lived at the home had a single room where they were able to see personal or professional visitors in private. Visitors told us "We are always made welcome and we turn up at any time". People could make choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their rooms, but most people spent their time in the communal areas during the day.

People told us the staff were kind, helpful and friendly. A relative told us "The staff are friendly and do the job well" and another told us "There's only been one we didn't like and she didn't last long".

Information was available about the home and what was available. However the home's website was out of date and did not reflect well the care and services on offer. The nominated individual acknowledged this.

Staff were aware of issues of confidentiality and did not speak about people in other people's hearing. When they discussed people's care needs with us they did so in a respectful and caring way. While we were having discussions with staff we saw that they were being attentive to people's needs, and made efforts to enable them to be involved in our discussions.

Staff recognised and celebrated achievements and successes with people. One person was engaged with a soft toy, and they were clearly gaining enjoyment from this. The member of staff engaged with the person and the toy which the person really enjoyed. One person told us about how much they were looking forward to celebrations for their birthday. They told us they had lovely food and a cake on their birthday which they were looking forward to again this year. Another person told us "It was my birthday the other day and I had a cake with candles".

We spent time observing the interactions between staff and the people they were supporting. There were many positive examples of interactions that supported people's sense of well-being. In particular we saw a member of staff supporting an individual who was becoming distressed as

Requires improvement

Is the service caring?

they could not find their husband. The staff member engaged with the person in a positive way, offered them physical comfort and discussed looking for a photograph of their husband together.

People told us that their requests regarding gender of care staff supporting them were usually respected. One person told us "I called for help on the loo the other day and a male came and I sent him away. I apologised to him later".

People's rooms were personalised. Some people were able to go out independently or with members of staff. For example one person had been taken to church at the weekend. Some people had daily newspapers and there were portable phones available so they could maintain contact with friends and family as well as local contacts. Relatives told us they had confidence in the home. One said "(Name of relation) broke her hip here while I was on holiday and they phoned me straight away and dealt with it really well".

Requires improvement

Is the service responsive?

Our findings

The home was not always responsive.

Each person had a care file which contained some information about their needs. We found the care plans were not sufficiently personalised to each individual and did not contain detailed information to assist staff to provide care in a manner that was safe and respected people's wishes.

People had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. At the time of the inspection there was a significant number of people living at the home with high care needs, which the registered manager told us had led to pressures on care delivery.

People's care files were unwieldy documents, and it was difficult to identify what people's current needs were or what actions staff needed to take to meet them. Information and daily notes were recorded in one recording system, care plans were kept in another file and a third file was kept in the registered manager's office with other information about people's care needs, medical reports and some assessments. Relatives we spoke with told us they did not recall any involvement in drawing up care plans but felt they had been consulted about people's care. One told us "I am deputy for the power of attorney on health and finance and I'm kept well informed over what's happening".

Daily notes were written by staff about the care they had delivered to people, but these were not linked to any detailed plans of care, so it was not possible to evaluate if the care delivered was in accordance with the plans and known wishes of people. Files contained a numerical dependency scale and monthly reviews, which reflected in a statistical way changes to people's needs but this was not reflected in any changes to a clear plan of care. Where plans and records were available they contained little detail and were not always up to date. For example one person's file indicated they had last had a bath on the 12 June 2015. The manager told us they thought this was because the records had not been completed rather than the person had not been supported to maintain their personal hygiene

The failure to maintain an accurate and complete record in respect of each person at the home of the care and treatment was a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they considered Hadleigh Court to be a specialist care home for people with dementia. Where people were living with dementia their care plans contained little information on how this impacted on their daily lives or the support they needed to retain skills they had and maintain their independence for as long as possible. Plans were not constructed in accordance with best practice for people with dementia. For example, files contained little personal information about people's social and personal history which is important in helping understand people's experience of dementia and how best to support them in the knowledge and context of the life they have lived. There was limited information from relatives or significant others in relation to people's history and in many files none at all, although the registered manager told us she was attempting to involve families in providing this information.

The failure to carry out a full assessment of the needs and preferences for care and treatment and the designing of a plan of care to ensure people needs and wishes are met is a breach of Regulation 9 (3) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some new care plans and risk assessment formats had been provided by the Care Trust as part of their quality monitoring and safeguarding process and the registered manager told us they would be changing the format to ensure that all care plans met that standard. While we were at the home the registered manager had obtained information to support the development of the care plans in line with best practice in dementia care.

People told us they would feel able to go to senior staff with concerns that they had, but not everyone told us this would be the registered manager as a first choice. People told us "I've got no complaints at all… the staff have always been kind to me" and "If I did have a problem I would go to x as I can talk to her". There was a copy of a complaints procedure on the wall in the hallway but this was out of date and did not match the procedure in the policy and procedures manual in the office. Where complaints and concerns had been raised there was not clear evidence of

Requires improvement

Is the service responsive?

the actions taken to address the concerns as this had not always been recorded or addressed in line with the complaints procedures. Complaints, concerns or comments had not been monitored or audited over time to identify any trends.

The failure to establish and operate an accessible and clear system for the monitoring of complaints is a breach of Regulation 16 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The nominated individual told us they would be overseeing the monitoring of complaints and concerns following the inspection.

The home had a programme of daily activities, provided by an activities co-ordinator who was at the home four days a week. Peoples care plans did not provide information about people's hobbies, interests and skills to help the development of person centred activities at the home.

However, we saw they were active in providing support to people to help them be involved whether on a one to one basis or in a group. People chose music they wanted to listen to and were engaged in word games, quizzes and craft. We saw the activities co-ordinator engaging with one person who was living with a significant dementia and physical frailty helping them colour a picture they wanted to give to a relative. The activities organiser wrote down what the person wanted to say and then asked them if they wanted to add kisses to the picture. The person said they did and the activities organiser did so. They then gave the pen to the person who added their own with a sense of pride and ownership. The activities organiser told us they had access to ordering any resources they needed or wanted to support people. They told us "People tell me what they want to do". They told us about some ideas they had for developing more person centred activities for people. For example they knew one person was an ex nurse, so they were preparing a bag full of bandages to be rolled and slings for the person to help with folding, because they knew they enjoyed being busy and feeling helpful.

Inadequate

Is the service well-led?

Our findings

The service was not well led. The registered manager and nominated individual had not ensured there were good systems for governance, quality assurance or safe care for people. Records were not fit for purpose; many were out of date and there were no audits of practice being carried out to enable the provider to judge the quality of the services provided or take action to address shortfalls. Notifications had not been sent to CQC as required by law.

At the time of the inspection the home was under a whole home safeguarding process. This had identified concerns that the nominated individual and registered manager had started taking action to address. However actions were being taken in response to concerns identified by other agencies rather than the service having been proactive in identifying where they needed development. The failure to have effective systems in place had led to people receiving unsafe or inappropriate care. In addition agencies providing support and advice had not always seen that their advice and recommendations had been implemented, or implemented in a timely way.

There was no evidence the registered manager had a clear vision for the home that had been shared amongst the staff group. Standards and expectations were not clearly laid out for staff and there had been ineffective monitoring of care delivery. For example the registered manager and other senior staff told us they were not aware of some of the staffing practices being carried out. There had not been regular staff meetings, supervisions or appraisals of staff performance, so opportunities to share good practice and develop a joined up and consistent philosophy of care were not in place. The registered manager did not have tools for assessing the numbers of staff needed to support people or the needed skills mix. They told us "It's just based on what I see and what the staff tell me". We were told that following concerns being raised senior staff and the registered manager were carrying out more spot checks and observation of staff practice, but these had not been recorded.

Communication systems between staff and management were not well developed. We observed a staff handover, where staff were updated on changes to people's needs, but there was little evidence of staff being directed in their duties, for example named staff being delegated to care for individual people. The main office was located in a central position which enabled people to speak with the manager if the door was open. It also enabled the manager to observe care practices and carry out on going monitoring. We received concerns prior to the inspection about the use of cameras and a monitor in the manager's office which was used to help the manager observe what was going on in the home, rather than them being present 'on the floor'. There was no evidence that the use of this monitor had been considered in the light of guidance issued by CQC regarding surveillance equipment and the nominated individual agreed to look into this further. No monitoring was being carried out in areas where people might be receiving personal or intimate care.

The registered manager confirmed that they had not carried out any audits of practice at the home, for example looking at safe delivery of medicines, environmental audits, staffing audits or falls analysis. They could not demonstrate to us how they had assured themselves of the quality and safety of the services provided. For example there were no clear systems for assessing the quality of the care planning systems or to identify how effective they were in supporting people's care. There was no clear system for assessing the level of staffing required or the skills that staff needed to carry out their role. The nominated individual confirmed they had not been aware that these areas were not being addressed. This told us they had not maintained effective oversight of the registered manager and the operation of the regulated activity.

No assessment had been made of how well the home was meeting the regulations governing care homes and care standards. Both the nominated individual and the registered manager expressed surprise at the number and level of concerns that had been identified. We asked the registered manager their view about how the concerns we had identified had arisen. They told us recently people had "needed more attention. We are trying to do everything properly now". However we identified issues had not been addressed for a long time and systems had never been in place or working effectively to manage people's care needs.

The failure to establish and effectively operate systems to monitor and improve the quality and safety of the services provided was a breach of Regulation 17 (1) and (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had booked a staff meeting for the 20 October 2015 to communicate issues

Is the service well-led?

and developments at the home with staff. They had also between inspection visits liaised with the local Skills for Care co-ordinator who had visited the home and left resources to help develop positive cultures of care and leadership skills. They had given a commitment to return and work with the nominated individual and registered manager to develop a more positive culture and look at issues such as leadership and developing action plans to improve the home. The registered manager had since the first inspection day implemented a staff communication book to help ensure information was passed on between shifts.

The home had not notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities. On the inspection it was identified that the home had not reported a number of expected deaths to the CQC, incidents of significant injury to people following a fall or two incidents where people had developed pressure ulcers at a significance of grade 3 or above as they are required to do by law. There were not clear systems in place to audit and assess risks to people and escalate concerns. This left people at risk of unsafe care or incidents and accidents being repeated.

The failure to notify the CQC of deaths at the home is a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

The failure to notify the CQC of injuries to individuals or the development of a pressure ulcer at grade 3 or above is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The home had sent a series of questionnaires to relatives and people at the service where appropriate asking them for their views about the service. We saw these had been returned some with comments that could be used to help improve the service. The registered manager told us that the results had not been collated or audited but they had been looked at and some changes made. We saw that two people had raised concerns about the laundry, that things went missing and that clothes were not always properly cleaned. The registered manager could not tell us what actions had been taken to address this but they were looking into getting a laundry person. The registered manager told us that feedback had not yet been given to individuals about the issues they had raised.

People were not protected by the home's systems for maintaining records. People's care plans did not identify people's up to date needs or risks associated with their care. Risk assessments were not up to date. Staff files did not contain the required information to ensure staff recruited were appropriate to work with potentially vulnerable people. Policies and procedures were inconsistent or out of date. For example some referred to out of date legislation, and most had last been reviewed in August 2011.

The failure to maintain accurate, complete and contemporaneous records is a breach of Regulation 17 (2) (c) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Information was given to the home about a local care providers association which offered advice and support to care providers, and the registered manager and nominated individual expressed their intention to work openly with agencies to improve the services they were providing.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (a) (b) (d) (g) Health and Social Care Act 2008 Regulated Activities) Regulations 2014 How the regulation was not being met: Risks to people living at the home had not been assessed and mitigated. The provider and registered manager had not ensured the safety of the premises. Medicines were not being stored securely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 (2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: The provider and registered manager had not ensured robust systems for the safe recruitment of staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (2) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: The provider and registered manager had not ensured effective staff training, supervision and appraisal systems were in place.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: The provider and registered manager had failed to ensure that people were treated with dignity and respect at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) and 9 (3) (a) and (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: The provider and registered manager had not ensured that person centred care was assessed and delivered in accordance with people's preferences and wishes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16 (1) and (2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: The provider and registered manager had not ensured that complaints and comments about the service were responded to appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider and registered manager had failed to complete notifications to the CQC concerning pressure areas over a grade 3 and other significant incidents or accidents at the service.
	Regulation 16 Care Quality Commission (Registration) Regulations 2009 How the regulation was not being met: The provider and registered manager had failed to complete notifications to the CQC concerning deaths at the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) and (d) Health and Social Care Act (Regulated Activities) Regulations 2014. How the regulation was not being met: The provider and registered manager had not ensured that an accurate, complete record was maintained of each person's care needs and how they were to be met. Other records were not accurate or up to date regarding the management of the home. The registered manager and provider had failed to establish systems for good governance of the service. The registered manager and provide had failed to establish systems to assess, monitor and mitigate risks to people's health and welfare.

The enforcement action we took:
We issued a warning notice to the registered provider on the 18 November 2015 in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We have set a timescale of 15 January 2016 by which the registered provider must address this breach.