RYSA Highfield Manor Limited

Highfield Manor Care Home

Inspection report

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Date of inspection visit: 8 January 2015
Date of publication: 23/02/2015

Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 1, 2 and 15 October 2014. Breaches of legal requirements were found and we issued a warning notice for breaches in medicines management. The provider was required to meet the regulation by 14 November 2014.

As a result we undertook an unannounced focused inspection on 22 December 2014 to follow up on whether action had been taken to deal with the breach.

Following the receipt of further adult safeguarding concerns about Highfield Manor Care Home we carried out an unannounced inspection at 5.40 am on 8 January 2015.

You can read a summary of our findings from the three inspections below.

Comprehensive Inspection of 1, 2 and 15 October 2014

This was an unannounced inspection on 1, 2 and 15 October 2014.

Summary of findings

Highfield Manor is registered to provide personal care for up to 46 people living with dementia. Nursing care is not provided. There were 45 people living at the home when inspected. The registered manager is also one of the directors of the provider RYSA Highfield Manor Limited. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

There were unsafe arrangements for the management and administration of medicines that put people at risk of harm. People were given sedative medicines routinely rather than when needed them and as prescribed by their GP. These people were subject to sedation at times when they did not need it and this placed them at risk of harm.

Policies about keeping people safe and reporting allegations of abuse were out of date and one member of staff was not sure how they should respond to abuse.

Any risks to people's safety were not consistently assessed and managed to minimise risks. For example, behaviours that may challenge others and emergencies had not been risk assessed and planned for so staff knew what action to take. People's needs were not reassessed when their circumstances changed and care plans were not updated or did not include all the information staff needed to be able to care for people. This meant that for some people prompt action or referrals were not made to the right healthcare professionals and they did not receive the care they needed. People's need for social stimulation, occupation and activities were not consistently met.

People's care and monitoring records were not consistently maintained and we could not be sure they accurately reflected the care and support provided to people.

Staff did not have the right skills and knowledge to provide personalised care for people living with dementia. This was because they did not have a full induction into care, the right training or regular support and developments sessions with their managers.

Staff did not fully understand about the Mental Capacity Act 2005, and how to assess people's capacity to make specific decisions or about those people who were being restricted under Deprivation of Liberties Safeguards. This meant that some people may have been unlawfully deprived of their liberty or had restrictions place on them.

Some people had lost weight and prompt action had not been taken to ensure they had high calorie and high fat foods such as cream to increase their weight. Food and fluid plans were not in place for people who were at risk of losing weight so that staff knew what action to take to support them.

Information about making complaints was not displayed and contact information was incorrect. There were mixed views from relatives about whether they felt able to complain about the home.

The systems in place and the culture at the home did not ensure the service was well-led. This was because people were not encouraged to be involved in the home. People were not consulted, staff were not consulted and the quality assurance systems in place did not identify shortfalls in the service. The service did not have effective systems in place to ensure it was well led and people received a good service.

There were enough staff on duty during the inspection to meet people's needs and staff were recruited safely to make sure they were suitable to work with people. There were staff meetings and handovers to share information between staff.

Staff were caring and treated people with dignity and respect. Staff knew people's basic care needs and some personal information about them. We saw good relationships and interactions between some staff and people.

At our last inspection in November 2013 we did not identify any concerns.

Focused inspection of 22 December 2014

After our inspections of 1, 2 and 15 October 2014 the provider was served a warning notice in relation to medicines management. This required the service to be compliant by 14 November 2014. We undertook this unannounced focused inspection to check that the breach of the regulations had been addressed.

Summary of findings

The provider had developed a plan to address the shortfalls with an independent pharmacist appointed by the local authority. The independent pharmacist was appointed because of the concerns relating to medicines management. We found that the provider had followed their plan in relation to meeting this regulation. However, medicines were not stored at their recommended temperatures and appropriate actions had not been taken when this was identified by staff. This was an area for improvement because the incorrect fridge temperatures could affect the effectiveness of people's medicines.

People's medicines had been reviewed by their GPs. Following these reviews the prescribing, dispensing and Medication Administration Records (MAR) were being updated to reflect these changes. Care plans were in place for people who were prescribed 'as needed' medicines with supporting information on "how I take my medicines". 'As needed' sedative medicines prescribed were administered infrequently. Staff managing medicines for people had been trained and their ability to safely administer medicines was monitored.

We will undertake another unannounced inspection to check on all other outstanding legal breaches identified for this home.

Focused inspection 8 January 2015

We inspected the home unannounced at 5.40 am in response to concerns being raised about the staffing levels, staff recruitment and care practices. The provider had not yet been required to submit an action plan as to how they were going to meet the breaches of the regulations we identified at our previous inspection. This meant we were not yet able to check the actions they had taken to meet the breaches identified at the October 2014 inspection.

We found two repeated and two new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These breaches were in relation to respecting people's dignity and choices, staffing, record keeping and assessing and monitoring the quality and safety of the service. You can see what action we told the provider to take at the back of the full version of this report.

We were unable to gain entry into the home until 6.15am because staff did not have access to the telephone and external entrance intercom. This was an area for improvement because staff were not able to respond to the telephone or make emergency calls if they needed to.

There were not enough staff on duty at all times to meet the needs of the people living at the home. This was because some of the 45 people who were living with dementia needed two staff to support them with their mobility and personal care. One of the staff members was appointed to work with one person at all times and should not have been included in the overall staffing levels.

At our inspection in October 2014 we identified that records were not accurate and this placed people at risk of unsafe or inappropriate care. At this inspection records did not reflect that some people had been dressed and returned to bed or sat in their armchair. Records also did not statewhen assessments had been completed or how any injuries had been sustained. This was a continuing breach of the regulations in relation to records.

At 6.15 nine of the 45 people were dressed in their day clothes and were asleep either in bed or in an armchair. All of these people were living with dementia and some may not have been able to determine what the time was when they were dressed by staff. People being dressed and put back to bed was not dignified and did not respect people or their choices about when they liked to get up.

There were not robust systems in place to determine and assess whether people's needs could be met and whether there was sufficient staff to meet their needs prior to them moving in the home. This was an area for improvement identified in October 2014 and at this inspection.

At our inspection in October 2014 we identified there were not effective systems in place to ensure people received a good and safe service. The registered manager was not at work and the three deputy managers were covering the absence. They had been able to cover the day to day management of the home and action the immediate concerns about medicines management. However, they had not had time to undertake some of the

Summary of findings

quality monitoring such as auditing accidents and incidents for any trends. This was a continuing breach of the regulation in relation to assessing and monitoring the quality and safety of the service.

Staff were recruited safely and checks on their suitability to work with people had been made.

We will undertake another unannounced inspection to check on the new and other outstanding legal breaches identified for this home.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

Comprehensive Inspection of 1, 2 and 15 October 2014

People were not kept safe at the home.

The management and administration of medicines were unsafe. People were given sedative medication routinely rather than 'as needed', as prescribed by their GP. This meant they were given sedation at times when they did not need it, which placed them at risk of harm.

Safeguarding procedures and training did not make sure that all staff knew and understood when and who they needed to report allegations of abuse to.

Risks were not always identified and managed to make sure people were kept safe.

People's records were not accurately maintained to make sure they reflected the care and support they had received.

Focused inspection of 22 December 2014

Medicines were safely administered and recorded but those requiring refrigeration were not safely kept within their recommended temperature range.

Administration records were complete. Care plans were in place for people prescribed medicines for challenging behaviour along with information about allergies and how a person preferred to take their medicines.

Focused inspection 8 January 2015

There were not enough staff to meet people's assessed needs.

People's records were still not accurately maintained to make sure they reflected the care and support they had received.

Is the service effective?

Inadequate 

Text unchanged from comprehensive inspection

Is the service caring?

Requires Improvement 

Comprehensive Inspection of 1, 2 and 15 October 2014

The service was caring but some improvements were recommended.

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

Staff respected people's privacy and dignity.

Staff had some understanding of people's preferences and how they liked to be cared for. Staff were not aware of everyone's life histories and the importance of using this information when providing care and support.

Summary of findings

People and their relatives were not involved in the planning of their care.

People's independence was not always promoted and people could not move between floors of the home without staff support.

Focused inspection 8 January 2015

Staff did not respect some people's choices or maintain their dignity by getting them dressed very early in the morning.

Is the service responsive?
Text unchanged from comprehensive inspection

Inadequate

Is the service well-led?
Comprehensive Inspection of 1, 2 and 15 October 2014

Requires Improvement

The home was not well-led.

Observations and feedback from people, staff and relatives showed us there was mixed views about whether the service had an open and inclusive culture.

People and staff were not asked for their feedback or asked to make contributions to the development of the service to the home.

The quality monitoring systems in the home were not effective to ensure the service delivered high quality care.

Focused inspection 8 January 2015

The quality monitoring systems in the home were still not effective to ensure the service delivered high quality care and to ensure people's needs could be met.

Highfield Manor Care Home

Detailed findings

Background to this inspection

This inspection report includes the findings of three inspections of Highfield Manor Care Home. We carried out all three inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The first was a comprehensive inspection of all aspects of the service and took place on 1, 2 and 15 October 2014. This inspection identified breaches of the regulations.

The second was undertaken on 22 December 2014 and focused on following up on action taken in relation to the breach of one of the legal requirements we found on 1, 2 and 15 October 2014.

The third was carried out on 8 January 2015 in response to concerns being raised with CQC.

You can find full information about our findings in the detailed key question sections of this report.

Comprehensive Inspection of 1, 2 and 15 October 2014

This inspection took place on 1, 2 and 15 October 2014 and was unannounced. We carried out a planned inspection on 1 and 2 October and returned on 15 October to gather further information. There were three inspectors in the inspection team and two inspectors visited on each date. We met and spoke with all 45 people living at Highfield Manor. Because most people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with six visiting relatives, a visiting social worker, a district nurse, a chiropodist and the hairdresser during the inspection. We also spoke with the registered manager, two deputy managers and five staff.

We looked at five people's care and support records, an additional six people's care monitoring records, all 45 people's medication administration records and documents about how the service was managed. These included staffing records, audits, meeting minutes, maintenance records and quality assurance records.

Before our inspection, we reviewed the information we held about the service. This included the information about incidents the provider had notified us of. We also contacted one commissioner and four health and social care professionals who work with people using the service to obtain their views. We had contact from four different relatives before the inspection who raised concerns with us. We also had contact with four additional relatives following the inspection who also raised concerns with us.

We asked the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they planned to make. However, the provider told us they did not receive the request and did not complete this. We resent our request for this information after the inspection. This information had not been received at the time of us completing this inspection and was not used to inform judgements in this report.

Following the inspection, the registered manager sent us information about policies and procedures, end of life care, survey results, staff training and the training plan.

Focused inspection of 22 December 2014

This focused unannounced inspection of Highfield Manor Care Home took place on 22 December 2014. There were 44

Detailed findings

people living at the home. This inspection was done to check that the warning notice we issued after our 1, 2 and 15 October inspection had been met. The team only inspected the service against one of the five questions we ask about the service; is the service safe? This was because the service was not meeting relevant legal requirements.

There was a pharmacy inspector and the lead inspector for this service in the inspection team. During the inspection we spoke with two people, the three deputy managers and two staff.

We reviewed the Medicines Administration Record (MAR) for 21 people, the medicines sections within care plans for four people, Topical Medicine Administration Records (TMAR) for six people, the medicines policy and seven staff training records.

Focused inspection 8 January 2015

This focused unannounced inspection took place at 5.40 am on 8 January 2014 by two inspectors. There were 45 people living at the home. This inspection was in response to a number of concerns raised about the staffing levels, staff recruitment and care practices at the home.

The registered manager/provider was not working in the home at the time of the inspection. One of the three deputy manager's had been identified by the provider as the named member of staff in the registered manager's absence. The three deputy managers were responsible for the day to day running of the home.

Before our inspection, we reviewed the information we held about the service. This included the information about incidents the provider had notified us of.

We checked 43 of the 45 people living at the home most of who were asleep. We spoke with three people who were awake, four staff and two deputy managers.

We reviewed the care records and plans for four people, the staffing rotas, the accident and incident records and the recruitment records of the last two recruited staff.

Inadequate

Is the service safe?

Our findings

Comprehensive Inspection of 1, 2 and 15 October 2014

People who were able to said they felt safe at Highfield Manor. One person said: "I'm comfy and happy here and I feel safe". We saw that other people freely approached and sought out staff. They smiled and responded positively when staff spoke with them. When people were upset or anxious they sought out staff to provide reassurance and comfort. This indicated people felt comfortable and safe with staff. For example, one person called out repeatedly and staff responded to the person's questions, gave them physical comfort and reassured them they were safe. Relatives told us they felt their family members were safe at Highfield Manor. However, we found significant shortfalls in the safety of the service.

We saw medicine stocks and management systems were audited on a monthly basis. We checked the controlled drugs storage and stock management systems in place. We found the stock and the controlled drugs record book balanced for the controlled medicines in use at the home.

The deputy manager responsible for ordering medicines told us they also audited the medication administration records each week. They said if any gaps or omissions were identified they checked against the stock to make sure that the medicine had been administered. They followed up with individual members of staff where gaps were noted. However, these audits were not effective as they had not identified the shortfalls we found.

The deputy manager told us there were nine staff who were trained to administer medicines. Records showed us three of these staff had their competency to administer medicines assessed in February and March 2014. However, six of the staff who administered medicines had not had their competency assessed. This meant that people could not be assured that these staff had the knowledge and skills to administer medication. There was no schedule to determine how often staff competency was going to be reassessed to ensure that staff were able to continue carrying out this task safely.

We looked at the medicines plans, administration and monitoring systems in place for people. People who had PRN (as needed) sedative medicines prescribed were given these medicines routinely rather than when they needed them. These medicines had been prescribed to be given 'as needed' rather than routinely. Therefore people had been given sedation at times when they did not need it, which placed them at risk of harm. There were no 'as needed' medicine plans in place to make clear to staff the circumstances when they should administer these medicines, the maximum dosage and the time between doses. We raised this serious shortfall with the manager and deputy managers on the 1 and 2 October 2014. When we returned on 15 October 2014 we found this practice had continued and people had continued to have sedative medicines on a routine basis. In addition to this, 'as needed' medicine plans were still not in place to advise staff when these medicines should be given.

For some sedative medicines, medication administration records did not detail whether half or a whole tablet had been administered. This meant that a stock balance could not be established and we could not be sure of the amounts that had been administered to the person. One person's sedative medication administration record had been signed for 11 times but there were19 tablets missing from the medicine blister pack. (This is a type of monthly medicine administration dosage packet dispensed from the pharmacy). This meant eight sedative tablets had been removed from the pack, but the records did not state what had happened to this medicine.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there were not appropriate arrangements for the administration, and recording of medicines.

The safeguarding policy was out of date, did not make references to offences under the Mental Capacity Act 2005 and did not include the correct details for the local authority for staff to report any allegations of abuse. Staff had been trained in safeguarding as part of their induction. All of the staff we spoke with were confident of the types of the abuse and how to report any allegations. However, one staff member said they would speak with a staff member if they witnessed them shouting at someone rather than reporting it but if it happened again then they would then report it. This was an area for improvement because the safeguarding policy did not provide staff with the contact information on how to report allegations of abuse and some staff may not have responded appropriately to any allegation of abuse.

People had risk assessments and management plans in place for falls, pressure areas and nutrition. However, there

were no assessments and management plans in place for other risks. For example, two of the three people who had bed rails to minimise the risk of them falling out of bed, did not have a risk assessment completed to ensure that bed rails were appropriate to meet their needs. People who sometimes showed behaviours that challenged others did not have these risks assessed and behaviour management plans were not in place. This meant that staff did not have information about how to manage people's behaviours in a safe and personalised way.

Two of the five people's care records included a personal evacuation plan. For the remaining three people this information was not available, therefore staff and emergency services may not know how to safely support these people in an emergency.

These shortfalls in risk assessments and management plans, and emergency plans were a breach in Regulation 9 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care and monitoring records were not consistently maintained and we could not be sure they accurately reflected the care and support provided to people. For one person daily records were not completed for one night and for another person their name was recorded differently in different records. Three people's fluid records had not been added up to make sure they had enough to drink, and according to the records we saw those people did not drink the target amount recorded on their monitoring records. Two people's weights were inaccurately recorded on their care plans and food and monitoring records. We found an eating and drinking plan for another person in one person's care plan. This was a potential risk because the care plan did not accurate reflect the care and support for this individual.

These shortfalls in record keeping were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and relatives said there were enough staff most of the time. One relative said: "Staff respond really quickly if you ask for help". The district nurse and chiropodist told us there were staff available when they needed them. However, some people gave us conflicting opinions that staff were not available at the times when they wanted support. One person said: "The staff seem to disappear completely in the evenings and you have to get undressed when they say and don't always have choice about what time to get up in the mornings". Another person said: "When I use my call bell at night it can be a while (for staff to arrive)… it feels that we have to adapt to the staff rather than the staff adapt to us".

We observed during the inspection there were enough staff to meet people's needs. The deputy manager acknowledged that additional staff were on duty because of the inspection so managers could be freed up to support the inspection. The number of staff on duty during the inspection did not reflect the usual number of staff working. We looked at the last four weeks' staff rotas and found they reflected the staffing levels the deputy manager and staff told us. Additional staff had been working between 8pm and 10 pm from 8 September 2014. The manager and deputy manager told us this was in response to an increase in people's needs. We explored with the manager and deputy manager how they determined the amounts of staff they needed. However, they were not able to demonstrate how they worked out staffing levels and whether it was based on people's individual needs. This was an area for improvement as they were not able to relate staffing levels to people's needs.

We looked at four staff recruitment records and spoke with one member of staff about their recruitment. We found that recruitment practices were safe and that the relevant checks had been completed before staff worked with people. This made sure that systems were in place to protect people from individuals who were known to be unsuitable.

Focused inspection of 22 December 2014

Medicines were safely kept. We undertook a stock check of a sample of medicines against the records and these were in agreement. Medicines were stored securely within locked medicines rooms or trolleys.

The service had one medicines refrigerator in use. The refrigerator records and refrigerator thermometer indicated the refrigerator had been outside of the recommended temperature range. Temperature records were not kept for the three medicines rooms but a thermometer in one room indicated that the minimum room temperature was above the maximum recommended temperature for the storage of medicines. The deputy managers had undertaken a number of medicine administration audits. However, they had not identified any concerns with the refrigerator

records or taken any action to address this shortfall. Appropriate arrangements were not in place to store medicines within their recommended temperature ranges. This was an area for improvement because the temperature may have affected the effectiveness of people's medicines.

The date when one medicine had been removed from the refrigerator and kept at room temperature had not been recorded. This was an area for improvement so that District Nursing staff were aware of how long the medicine had been out of the fridge and could ensure it was used within the recommended time.

Medicines administration was recorded appropriately. Care plans were in place for people prescribed 'as needed' sedative medicines for when they were upset and presented behaviours that could challenge others. These included minimum dose intervals and the maximum number of doses in 24hours. Supporting information on "how I take my medicines", allergies, and if the person was aware of their needs and could request medicines was also documented.

'As needed' medicines prescribed for when people were upset and presented behaviours that could challenge others were administered infrequently and only following a secondary opinion and review by another deputy manager. The covert administration of medicines had been authorised for one person by their GP, following a mental capacity assessment and best interest meeting with a family member and health and social care professionals. Covert administration is where a medicine is disguised in food or drink when the person does not consent to taking the medicine. Specialist pharmacist advice was also documented on how to administer the medicines covertly and retain the medicines effectiveness. We checked the administration records for one person against the medicines they received and the records reflected the doses that had been administered.

Seven members of staff administered medicines and we saw their training and supervision records to show they had been assessed as competent.

Following our last inspection a deputy manager had met with GPs from the two local practices and people's medicines had been reviewed. The use of 'as needed' sedative medicines had been reduced for most people.

These changes in prescribed medicines had been shared with the community pharmacy and the Medicines Administration Records (MARs) were being revised to reflect the prescribing changes.

Focused inspection 8 January 2015

We arrived at the home at 5.40 am and repeatedly phoned the home and rang the external entrance intercom to try and gain entry. We were able to see staff walking about the home during this time but they did not respond to the telephone or the intercom. At 6.08 am a staff member answered the external entrance intercom and told us to wait. We were then let into the home at 6.15 am and the senior care worker explained they had not responded to the telephone because they did not have the portable telephone with them and that the entrance intercom was only audible in the reception area. We raised the lack of telephone response as a matter of concern with the deputy managers who acknowledged that the staff should have the telephone with them to be able to make and respond to emergency calls. This was an area for improvement so members of the public could contact the home during the night and early morning and staff could make outgoing calls.

There were not always enough staff on duty to meet the needs of people. The deputy manager provided us with the staffing rotas for the week of the inspection. There were four care staff on duty at night and one of these members of care staff was allocated to provide constant support and guidance to one person. This meant there were three staff for 44 people at night. We also reviewed the staffing levels during the day. There were six or seven care staff on duty and one of these members of care staff was allocated to provide constant support to one person. This meant there were five or six care staff working over four living units for 44 people during the day. In addition to this there were two deputy managers on duty each day working 7am to 6 pm who were responsible for the day to day running of the home and the medicines administration. Twice a week there were three deputy managers on duty.

The deputy manager went through people's assessed needs with us. One person was funded by the Clinical Commissioning Group to have constant support from a designated staff memberand of the remaining 44 people, four of them needed two staff to support them with washing and dressing, hoisting and repositioning. A further six people needed either one or two staff to support them.

Inadequate

Is the service safe?

One person was cared for in bed and needed two staff to reposition them and provide personal care. This showed us there were not consistently enough staff to be able to safely meet people's needs. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The deputy manager told us in response to concerns raised by people's relatives about the laundry management at the home the provider had agreed to appoint a member of staff to do the laundry so this task could be taken away from care staff.

We looked at the staff recruitment records for the two most recently recruited staff. We found that recruitment practices were safe and that the relevant checks had been completed before staff worked with people. This made sure that systems were in place to protect people from individuals who were known to be unsuitable.

At our inspection in October 2014 we identified a breach of the regulations in relation to record keeping. At this inspection we identified further concerns with the completion and accuracy of the care records for people. For example, care records did not reflect that people had been dressed and either put back to bed or sat in their armchair. Records had not been completed for the previous night for one person who had recently moved into the home and the front sheet of the daily records had the incorrect name for this person in that bedroom. This meant staff did not have the correct information as to who was staying in that bedroom.

For one person, who had recently moved into the home, the provider had not completed an assessment of their needs before they came to stay. This meant there was not an accurate record of this person's care and support needs so that staff knew how to care for them on their arrival at the home. The deputy manager then completed this the day after they arrived. On the morning of the inspection this person had bruising on their arms but these marks were not recorded on a body map. Their assessment identified they were at risk of bruising and the lack of recording about marks and bruising on their body placed them at risk of unsafe care. This was because staff were not able to establish when the bruising or marks had occurred.

This was a continuing breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This placed people at risk of unsafe or inappropriate care because there were not accurate records.

Inadequate

Is the service effective?

Our findings

(Text unchanged from comprehensive inspection)

Requires Improvement

Is the service caring?

Our findings

Comprehensive Inspection of 1, 2 and 15 October 2014

One person told us staff respected their privacy and dignity. They said: "They always knock on the door; they are gentle when they help me wash and they keep me covered up". We observed staff respecting people's privacy; they knocked on people's bedroom doors and sought permission before going in. On the second day of the inspection one person had a fall in the ground floor lounge at lunchtime. The managers and staff managed the situation calmly reassured the person and called paramedics. Staff maintained the person's dignity by using portable screens whilst they were being examined.

Overall, relatives we spoke with were positive about the care provided. Relatives' comments included: "The staff are really friendly", "For me this has become a home from home because they have made me so welcome" and "They respect me as well".

Staff were warm in their approach and treated people with compassion and respect. For example, one person was distressed and staff listened to them, offered them a cuddle and reassured them. The person relaxed and then chatted and smiled with staff. In the main, staff responded when people called out and staff spent time talking with people when they asked for staff attention.

Staff had a basic understanding of people's needs, some of their personal preferences and the way they liked to be cared for. However, people were not routinely consulted or involved in developing their care plans. Relatives had been involved in people's assessments and had signed some people's care plans. However information gathered on people's life histories and personal preferences was not used to plan people's care, support and social stimulation and occupation. This meant that people were not able to engage in meaningful activities and were not kept occupied doing things that were important to them.

We recommend that people and or their relatives be involved in planning their care and support. People's life histories and personal preferences should be used to inform their care is planned and delivered. This is so people receive a personalised service.

People's independence was not actively promoted. We did not see people being involved in activities of daily living such as making drinks, laying tables or helping with other tasks around the home.

During the inspection people moved freely about the floor they were living on. However, one relative told us people were routinely told to 'sit down' when they visited. Two people commented that they were not able to move independently about the home because they did not know how to work the lift and were reliant on staff to use it. They said they had previously used the ground floor lounge and gardens and now they were asked to use the second floor lounge and this meant they felt more isolated.

We recommend that people's independence is promoted so they are able to freely move about all areas of the home and are involved in daily living activities.

Relatives told us they were free to visit when they wanted. However, one relative told us they were discouraged from visiting at mealtimes and they had been made to feel uncomfortable about chatting with their family member during a mealtime visit. We asked the manager whether there were any restrictions on visiting and they told us they had introduced 'protected' mealtimes so that people could eat without distractions. They said that they had advised relatives they could have a meal in private with their family member if they wished.

Focused inspection 8 January 2015

Staff spoke fondly of the people they cared for and the people who were up and awake were relaxed with the staff. We observed the day staff supporting people to the dining area for breakfast. They walked with people at their pace and chatted with them and people smiled in response.

On our entrance into the home at 6.15 am staff told us there were two people who were up and dressed. Both of them were living with dementia and were happily chatting with us, each other and staff. They confirmed they were happy to be up and about at that time of the morning.

We then checked 41 of the 45 people in the home and found nine people who were dressed in their day clothes and were asleep. Three people were dressed in day clothes and were asleep in armchairs. The six other people were asleep in bed in their day clothes. We checked four people's care plans and their preferred times for getting up.

Requires Improvement

Is the service caring?

None of the care plans included they liked to get up before 6am. All of the people who were dressed and asleep were living with dementia and may not have been able to determine what the time was when they got up and dressed and returned to bed. This was not dignified and did not respect their recorded choices and preferences of when they liked to get up.

The deputy managers confirmed on their arrival at 7am they would only usually expect the two people who were up on our arrival to be up washed and dressed on a regular basis. This was based on their choice to be up early and walking about the home. The deputy managers said there would sometimes be two other people up as well if they were awake and walking about the home. These two people were dressed but both were asleep, one of them was in bed. The other person was asleep in an armchair in one of the second floor lounges with the lights off. When we asked staff about who the person was, they turned the lights on and woke the person up. We asked the person if they wanted to go back to sleep and to have the lights turned off they confirmed they did. The staff had not respected this person was asleep and woke them up for no reason.

People being dressed and put back to bed was not dignified and did not respect people or their choices about when they liked to get up. This was a breach of Regulation 17 (1) (a)(b) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One of the deputy managers accompanied us to check on some of the people who were dressed and in bed or their armchairs. They confirmed these people should not have been dressed in their day clothes if they were asleep and should not have been dressed before 6am.

We reviewed the care records for the people who were in bed asleep dressed in day clothes or in an armchair. None of the records reflected the reasons for them being dressed at that time of the morning. Staff told us that people were changed into their night clothes when they were ready for bed and washed and dressed when they got up in the mornings. However, this did not reflect our findings during the inspection. The two deputy managers told us concerns had been raised previously about night staff getting people dressed as early as 4.30 am. They had a meeting two weeks earlier with the staff involved.

Inadequate

Is the service responsive?

Our findings

(Text unchanged from comprehensive inspection)

Requires Improvement

Is the service well-led?

Our findings

Comprehensive Inspection of 1, 2 and 15 October 2014

There was not an inclusive and open culture. The manager and deputy manager told us they did not routinely consult with people. Some people who were able to told us they were not involved in developing the home or consulted about things like activities. People living with dementia were not given the opportunity to share their views and contribute to the running of the service.

Relatives had an opportunity to be involved and were consulted about the home. However, not all relatives felt they were encouraged by managers to be involved. There had been a relative's meeting in July 2014 and four relatives had attended. The manager had arranged for a small number of visitors and relatives to attend a dementia awareness session. Three relatives told us: "I feel like the doors always open", "Any questions we've had they've been very honest", "(manager) checks that I'm happy with everything", and "I filled in a form the other day about what could be better". We saw six compliment letters from relatives. People's relatives had recently completed surveys and the manager told us they had followed up with individual relatives any concerns they raised. However, these surveys were not dated and did not feed into any development plan to ensure that the feedback was used to improve the service.

The management structure of the home consisted of the registered manager was also one of the directors of the provider, the deputy manager responsible for the day to day running of the home and two additional deputy managers

Staff and managers told us there were handovers at the start of each shift where they discussed each person and any change in their needs. They also discussed any urgent matters and plans for the day. Although staff told us and records showed us there were regular staff meetings, staff did not have the opportunity to regularly discuss issues, express their views and influence the development of the home. From discussion with the managers, staff and from meeting records there was no evidence of how learning from incidents, accidents, safeguarding and compliments, was shared with staff to improve the service provided.

Three staff told us they knew how to whistleblow and there were policies in place to support this. We saw an example where a member of staff had raised concerns about another member of staff and the manager had taken appropriate action.

Prior to our inspection we had asked the provider to complete a Provider Information Return (PIR) containing information about the operation of the home. However, the provider told us they did not receive the request and did not complete this. We resent our request for this information after the inspection. However, the provider had not returned this information as required, and therefore this information could not be used to inform judgements in this report.

Policies and procedures were out of date and some included incorrect information. If staff relied on these policies they would not have had the correct information and this may have placed people at risk of not receiving the right care and support. The policies and procedures that were sent to us were for the provider's other care home. Policies such as the complaints, safeguarding policy and quality assurance policies differed to those we saw in the home and staff may not have been sure which were the correct policies to follow.

Notifications had been made to us for a majority of incidents. However, the manager had not notified us of safeguarding allegations and investigations as required by the regulations. This meant the provider had not shared information with us appropriately regarding safeguarding allegations and we were reliant on the local authority to notify us of these incidents.

This was a breach of Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009 because the provider had not notified the Commission of incidents affecting people.

The quality assurance systems in place were not effective and did not drive improvement in the quality of care and service provided. For example, the monthly care plan audits identified shortfalls but these were not followed up to make sure the issues had been addressed, it was not clear how any actions identified from other audits were followed up and the quality assurance policy referred to having a development plan but this was not in place.

Requires Improvement

Is the service well-led?

The quality assurance systems were also not effective in assessing and monitoring the quality of the service. The provider and management team had not identified the significant shortfalls we found during the inspection.

These shortfalls in how well led the service was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Focused inspection 8 January 2015

Following our inspection in October 2014 the provider entered into a voluntary agreement with us not to admit any further people into the home. This was in response to the concerns identified around medicines management. The provider admitted two people into the home on the day we carried out our unannounced inspection to review whether the warning notice for medicines management had been met. One of the directors of the provider had undertaken an assessment of needs for three new people who had been admitted into the home. However, they had not recorded the assessments or checked with the deputy managers, who were operating the home on a day to day basis, whether they could meet these people's needs or whether there were enough staff to meet their needs. This was of concern and improvement was needed because we identified at our inspection in October 2014 that there was not a system in place for assessing people's needs and calculating staffing levels.

We reviewed the accidents and incidents since October 2014. Accidents and incidents were recorded but there had not been audits of accidents and incidents since October 2014. This meant the provider was not aware of any patterns of when accidents happened so they could plan to minimise these where possible.

The deputy managers acknowledged they had not been able to undertake some of the quality monitoring audits and checks such as unannounced visits during the night. This was due to constraints on their time whilst covering for the absence of the registered manager. However, they had held a relatives meeting and had spent time in the home late into the evenings.

These shortfalls were a continuing breach of Regulation 10 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not protected from the risks of unsafe or inappropriate care because the provider did not have a system to identify, assess and manage the risks to people's health, safety and welfare.

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 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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving unsafe or inappropriate care because they had not assessed, planned and delivered the care to meet service user's needs and ensure the welfare and safety of each service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Comprehensive Inspection of 1, 2 and 15 October 2014 and Focused inspection of 8 January 2015** The registered person had not ensured that service users were protected from the risks of unsafe or inappropriate care because they had not maintained accurate records of the care and treatment provided to each service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person did not have suitable arrangements in place to ensure that persons employed for the purposes of carrying on the regulated activity received adequate training, supervision and appraisal.

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 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person did not ensure that service users were protected from the risks of inadequate nutrition and hydration by means of the provision of a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service user's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person did not have an effective system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by service users, or person's acting on their behalf.

Regulated activity	Regulation

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 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Comprehensive Inspection of 1, 2 and 15 October 2014 and Focused inspection of 8 January 2015** Service users who used services were not protected from unsafe or inappropriate care because the registered person did not regularly assess and monitor the quality of service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person did not notify the Commission of incidents affecting people living at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Focused inspection of 8 January 2015** The provider had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed to safeguard the health safety and welfare of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Focused inspection of 8 January 2015** The registered person had not made arrangements to ensure the dignity of people and did not treat people with consideration and respect.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Comprehensive Inspection of 1, 2 and 15 October 2014** The registered person was not protecting service users against the risks associated with the unsafe use and management of medicines. **22 December 2014** The provider is now meeting this regulation

The enforcement action we took:
We have issued the provider with a warning notice relating to the management of medicines. The provider must comply with this regulation by 14 November 2014.