RYSA Highfield Manor Limited

Highfield Manor Care Home

Inspection report

44 Branksome Wood Road
Bournemouth
Dorset
BH4 9LA
Tel:01202769429
Website:

Date of inspection visit: 13,14 and 16 July 2015
Date of publication: 02/10/2015

Ratings

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

Overall summary

This inspection took place on 13, 14 and 16 July 2015 was unannounced. The inspection was carried out in response to safeguarding concerns.

We last inspected Highfield Manor Care Home in March 2015 and we did not identify any breaches in the regulations.

Highfield Manor is registered to provide personal care for up to 46 people living with dementia. Nursing care is not provided. There were 38 people living at the home at the time of the inspection. The registered manager, who was also a director of the registered provider, was not working in the home 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.

At this inspection we identified serious shortfalls and breaches of the regulations. You can see some of the action we have taken at the end of this report.

Summary of findings

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

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

People's needs were not fully assessed by staff working at the home before they moved in. This meant care plans were not developed until the person was already at the home. This placed them of risk of not having their needs met when they moved in.

Risks to people were not fully assessed and management plans were not always in place to minimise these risks. For example, plans and the support were not in place to manage the risk for people who had epilepsy, people who had multiple falls and sustained injuries, and those people who need support to mobilise safely.

People did not always receive the care and support they needed and this placed them at risk of harm or neglect. Their health and care needs were not always met because the care and support they needed was not delivered. People who were living with dementia who were unable to express their views, those who had vulnerable skin, had complex mental health conditions, or had lost weight,or needed end of life care were particularly at risk. Action was not consistently taken when people sustained injuries or they were unwell. People's pain was not assessed to make sure people received adequate pain relief.

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

People were not supported to eat and drink in safe, respectful and dignified way. People were not informed what they were eating, they were not given choices and people were supported to eat by having cutlery tapped or cutlery pushed on their mouths without any conversation or waiting until they opened their eyes. Staff did not give people food and fluids in line with their specialist diets and this placed them at risk of choking and the risk of food or fluids entering their lungs. Some people who were losing weight did not have their food and fluids effectively monitored to make sure they were eating and drinking enough.

Not all of the staff were caring in their approach to people. Some staff did not smile at people or reassure them when they were upset or worried about things. However, staff who had worked at the home for a number of months spoke fondly of the people they supported and cared for. Most of these staff were warm and friendly in their approach to people.

Some people's medicines were not safely managed, recorded or administered. This was because one person's medicines were stopped by the staff at the home without the agreement of the GP, other people's creams were not applied as prescribed and some records were not accurate.

The systems for keeping people safe from abuse were not effective and this placed people at risk of harm and abuse. Not all staff had been trained and not all would report allegations of abuse. We identified two allegations of abuse that had not been reported to the local authority and CQC. No action had been taken in response to one of these allegations.

The service was not fully meeting the requirements of the Mental Capacity Act 2005. Staff were not fully aware of the principles of the Mental Capacity Act 2005, making best interest decisions. They did not know which people were being deprived of their liberty and who had Deprivation of Liberty Safeguards (DoLS) applications or authorisations in place.

Other risks to people in the home were not managed. There were not any means of cooling some areas of the building and action was not taken to repair a fire door that was off its hinge for thirteen days. There was an unpleasant smell in the lowered basement where people sat and ate their meals. The building was not suitable for people living with dementia and did not take into account national good practice. Some people's evacuation plans for the emergency services were not up to date.

Summary of findings

There were not enough staff to meet people's needs on the first day of the inspection. There was not any way of assessing how many staff they needed to meet people's needs. Staffing levels were increased following us feeding back our serious concerns at the end of the first day.

Most staff did not have the knowledge, experience or communication skills to be able to understand and communicate effectively with people who were living with dementia. Staff were not recruited safely, they did not receive any formal support sessions and they did not all have the training they needed to be able to meet people's needs.

Overall, people told us and during the inspection we saw that staff responded quickly to call bells. However, three people did not have access to a call bell, including one person who was receiving end of life care. There was no call bell in their bedroom for staff to call for assistance.

The home was not well-led and there were no clear management arrangements in place at the home. There was not an open and transparent culture at the home. The findings throughout the inspection showed there was a failure to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk. In addition, there was a failure to assess, monitor and improve the quality and safety of the services provided. The systems in place had not identified the shortfalls we found for people or driven improvement in the quality of care or service provided.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

People were not kept safe at the home.

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

The management and administration of medicines was not consistently safe. People did not receive their medicines as prescribed.

There were not enough staff to meet people's needs. Some staff were not recruited safely and some staff did not have the skills to be able to meet people's needs.

Safeguarding allegations were not referred to the local authority and not all staff knew how to keep people safe.

Some areas of risks in the building were not managed.

Is the service effective?

Inadequate

People's needs were not effectively met.

Staff did not have the right skills and knowledge, training and support to meet people's needs.

People's rights were not effectively protected because staff did not understand the implications of the Mental Capacity Act 2005.

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

Some people did not receive appropriate support to meet their health care needs to ensure that they were comfortable and protected from harm. Most people were referred to specialist healthcare professionals when needed.

Is the service caring?

Inadequate

The service was not always caring.

Some people did not receive the care and support they needed when they were receiving end of life care.

Not all of the staff were caring in their approach to people.

Some people's privacy and dignity was maintained.

Is the service responsive?

Inadequate

The service was not responsive to people and their needs.

People's needs were not always assessed so staff knew what care they needed. Staff did not always provide the care to people that was included in their plans.

People did not have things to stimulate them and keep them occupied.

Summary of findings

Complaints information was displayed but it was not clear what actions were taken in response to complaints.

Is the service well-led?

Inadequate

The home was not well-led.

There was not a clear management structure in place.

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

Highfield Manor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13, 14 and 16 July 2015 and was unannounced. The inspection was undertaken in response to safeguarding concerns. There were three inspectors and an inspection manager in the inspection team. Two inspectors or an inspector and an inspection manager visited on each day.

We met and spoke with 34 of the 38 people living at Highfield Manor Care Home. 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 two visiting relatives, two visiting social workers, a community mental health nurse and a district nurse. We also spoke with the acting manager, two deputy managers and nine care or support staff.

We looked at 11 people's care and support records and care monitoring records, all 38 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 did not contact any commissioners because the majority of people living at the home funded their own care.

We had contact from a relative and visiting social care professional before the inspection who raised safeguarding concerns with us. During the inspection a social worker from the local authority safeguarding team was visiting the home investigating a separate allegation of abuse.

Following the inspection, a deputy manager sent us information about relative and residents meetings, their heatwave plan and means of cooling the building, and staff training overview records.

Inadequate

Is the service safe?

Our findings

Because most people were living with dementia they were unable to tell us whether they felt safe. We observed some people responding positively with smiles when staff approached them. However, we also observed that some people did not react or give any eye contact when staff interacted and spoke with them. One person was distressed when some staff entered their bedroom but were calmed by our reassurance and presence.

We looked at the medicines management systems in place at the home. Medicines were stored safely and there were systems in place for storing medicines that needed refrigeration. Some liquid medicines were dispensed in single dose sealed pots. This reduced the risks of liquid medicine administration errors. We checked the medicine storage and stock management systems in place. We checked the stock for some medicines and found the stock and the medicine record book balanced for those medicines.

The two deputy managers were responsible for the medicines on two living floors. One deputy manager was responsible for people's medicines on the lower basement and ground floor, and the other deputy manager took responsibility for people's medicines on the first and second floor. The deputy managers showed us they audited the medicines they were responsible for every month. This meant that because the deputy managers were checking the systems they were each responsible for, some of the shortfalls in medicines management had not been identified. Staff told us the management consultants had also audited medicines but these audits had not been provided so they were not aware of the outcome of the audits.

One person who was receiving end of life care, had not had all of their medicines administered as prescribed. This decision not to administer all of these medicines was made by staff and not the person's GP. This placed this person at risk of harm because they had not received all of their prescribed medicines.

Some people's prescribed creams were not always applied as prescribed. For example, staff had not signed for one person's prescribed soap substitute on nine different days over a month.

At our inspection of December 2015 we identified that the date when one medicine had been removed from the refrigerator and kept at room temperature had not been recorded. We identified this as 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. At this inspection in July 2015 we identified that the date had been recorded on the person's insulin pen but this had not been recorded on the person's corresponding Medicines Administration Record (MAR) sheet. This meant staff at the home could not monitor when the insulin pen was started.

Risks to people were not fully assessed and management plans were not always in place to minimise these risks. One person, who had moved out of the home following safeguarding concerns being raised, did not have an epilepsy risk management plan in place. There was not any plan to direct staff how often to check the person or what action they should take if the person had a seizure. In addition to this, a visiting social care professional and relative raised concerns that staff had not responded when they used the call bell. The call bell records showed that on one occasion it took staff 14 minutes to respond to this individual. The lack of an epilepsy risk management plan and delay in responding to requests for help placed this person at risk of harm and of not receiving the care they needed.

Another person had a number of falls and sustained some injuries. However, staff were not aware when these injuries were sustained and the records did not include this information. The risk management plan in place did not consider the use of an alarm mat to alert staff when the person got out of bed. In addition to this on two occasions during the inspection this person did not have their call bell. Two visiting health and social care professional raised concerns with us that they had not been contacted by staff at the home following a change in this person's behaviours and the increase in their falls.

A third person's Personal Emergency Evacuation Plan (PEEP) included the incorrect room number which was on the first floor and this person was accommodated in the lower basement. The plan did not reflect the evacuation plan for escape from the lower basement. This meant emergency services and staff did not have the correct information as to how to safely evacuate this person.

Inadequate

Is the service safe?

This person was also observed on different days walking unsupervised and at other times holding on to the arms of staff. When the person went out of the home they were given a walking frame. Their moving and handling and falls care plan included contradictory information about whether the person could walk unaided or was to use a walking aid to minimise the risks of falling. Staff told us the person varied as to whether they would use a walking aid. This meant the risks to the person were not properly assessed and minimised and staff did not have clear directions as how to support the person.

During the inspection the fire door to the first floor lounge was not attached to the top hinge. This meant the door could not be closed to safely compartmentalise the area. Staff told us and a handwritten note showed this faulty fire door had been identified on 3 July 2015. However, the door still had not been repaired by the end of the inspection thirteen days later. We drew this to the attention of the management team during the inspection. The deputy manager confirmed the week following the inspection the door had been repaired.

Most care staff working at the home did not have English as their first language. The two staff who were working with people in the lower basement on 13 July 2015 were not able to explain how they supported people or fully understand questions we asked them about people's care. They were caring for people who had complex physical health and some behavioural needs because they were living with dementia. Five of the care staff had not received any training in dementia care and these five included two of the staff that were working alone with people living in the lower basement floor on both 13 and 14 July 2015. This meant staff could not understand and fully communicate with people living with dementia some of whom had complex ways of communicating.

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

13 people were living in the lower basement and on 14 July 2015 six people were seated in a corridor seating area. There was no natural light or windows and the temperature was 27 degrees centigrade. There was not any means of cooling the lower ground floor. Staff told us fans had been used in the past but they were concerned about the risks of using fans with people living with dementia. Staff told us air conditioning was available in other areas of the home but that this was not routinely used as it was too expensive. One person said, "I'm a bit browned off there's no fresh air I like to get out and get some air". Staff told us that people could access the garden areas with staff support. However, we did not observe anybody who lived in the lower basement accessing the garden during the inspection. We noted that other areas of the home were also hot. There were not any systems in place to monitor and record the temperature for the home. There was not any heatwave emergency plan in place that reflected national guidance so that staff knew what action to take in temperatures over 26 degrees centigrade. The deputy manager told us the week following the inspection that the registered provider had agreed to purchase two portable air conditioning units. We have not been able to establish whether this action has been taken.

In addition to this there was a strong unpleasant smell of stale urine in the seating and dining area in the lower basement during the inspection. This is the main area for people living on this floor to eat their meals. We observed people eating their lunch in this room, whilst there was an unpleasant smell and the temperature was 27 degrees centigrade. This meant the premises were not clean and standards of hygiene were not maintained.

The shortfalls in the cleanliness the building were a breach of Regulation 15 1 (a) (2) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager and two deputy managers confirmed there was not any system in place for identifying how they calculated the staff numbers needed to meet the needs of the people living at the home. We identified this at our inspections in October 2014, January 2015 and March 2015. At the inspection in March 2015 a deputy manager told us they agreed to look into the use of dependency assessment tools to assist in making a more robust assessment in determining appropriate staffing levels. At this inspection the acting manager told us they had identified there were insufficient staff during the day and night to meet the needs of the service users. However, they did not have the authority from the registered provider to change the staffing levels to make sure people were safely cared for or supported.

Inadequate

Is the service safe?

The acting manager and a staff member raised concerns with us that staff did not have enough time to spend quality time or provide care in an unhurried way. One staff member told us there were not enough staff to meet the needs of people. They said that because the staffing levels had been reduced by one member of staff, this had an impact on the amount of time they could spend with people. This was because there were eleven people that needed two staff to provide their personal care, reposition or move them. In addition to caring responsibilities staff were responsible for the doing the laundry, and at night they were responsible for cleaning all communal areas and the main kitchen.

On the first day of the inspection in the lower basement there were two care staff caring for 13 people. There were three people cared for in bed who needed two staff to support and care for them in relation to two hourly repositioning and personal care, and one person who needed two staff for personal care and transfers using a hoist. This meant that whilst the two staff were supporting and providing care to a person the other people were unsupported and unsupervised. All of the people were living with dementia. On the first and second floor there were seven people being cared for in bed. There were three care staff to care and support these seven people who needed two staff to provide personal care, reposition them and move them. One person who was receiving end of life care was living on the second floor. Staff from the first floor were supporting this person alongside caring for six other people who were being cared for in bed that day. There were insufficient staff to meet the needs of people during the day and night. This was supported by the shortfalls in people's care and support we observed.

On our return the following day the staffing levels had been increased by one member of staff during the day and night. The acting manager and deputy managers told us this was in response to our findings and not based on any ongoing assessment of people's dependency.

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

Information about safeguarding adults from abuse and how to report allegations was displayed in communal areas. However, staff including the management team did not respond appropriately to allegations of abuse. There were two separate allegations of abuse made about two different staff members but these were not referred to the local authority or the commission. One of these allegations had been investigated internally, and had not been reported to either the local authority who are the lead safeguarding agency or the commission on the guidance of the registered provider. The other allegation had not been acted on. The staff involved told us they understood their responsibilities under safeguarding and acknowledged they knew the allegation should have been reported.

10 of the 26 staff had not received any specific safeguarding adults from abuse training apart from information given to them during their induction. We asked staff about their understanding of safeguarding, abuse and what action they would take if they witnessed a staff member harming a service user. One member of staff told us, "If I saw someone hit someone I would keep an eye and if they did it again I would report them". This placed people at risk of harm, abuse and improper treatment.

During and following the inspection we raised safeguarding alerts for some individuals and the whole of the home because of the serious shortfalls we identified.

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

We looked at three staff recruitment records and spoke with one member of staff about their recruitment. Two of the staff were recruited through an agency and their records included up to date criminal record checks, fitness to work questionnaires, proof of identity and right to work in the United Kingdom and references from appropriate sources, such as current or most recent employers. However, another staff member started work at the home on 6 July 2015 but their application form was not completed until 7 July 2015. No references or evidence of suitable conduct had been obtained or the reasons why the person left their previous care position. A DBS (criminal records check) from a previous employer was in the staff member's records but a DBS adult first check had not been completed to establish whether the person was listed as barred before they started work. There was no proof of the person's identification. The acting manager and staff told us the directors of the registered provider interviewed staff

Inadequate

Is the service safe?

by telephone. There were not any records of the interviews to assess the suitability and fitness of staff. This meant that people were not protected as far as possible from individuals who were known to be unsuitable.

The shortfalls in ensuring fit and proper persons are employed were a breach of Regulation 19 (1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place for the regular servicing of equipment and aspects of the building such as lift servicing and electrical testing. The fire systems and alarms were tested on a weekly and monthly basis. However, as previously identified prompt action was not taken to address shortfalls such as a fire door not closing properly.

Inadequate

Is the service effective?

Our findings

In the lower basement people were not given the opportunity or asked whether they wanted to sit at the dining table for their meal. They all remained where they were sat in the corridor in the lower basement. Staff did not offer people a choice of drink and they were given water. They had aprons placed on them without being asked. Their cutlery was placed on a table placed in front of them without staff talking to them.

One person asked what was for their lunch and the staff said, "I don't know what you've got for dinner". Staff placed a plate of food in front of each person and said, "This is your lunch". Staff did not describe what the meal was. People were not offered a choice of food or given any condiments. Staff told us that it was not unusual for people in the lower basement not to be given a choice of meals. They said they were not given the opportunity to choose from two plates of food or choose each morning what they wanted to eat as was observed at the last comprehensive inspection in March 2015. No explanation was given as to why this practice had stopped for people in the lower basement.

We observed some staff in both the main dining room and lounge and lower basement stand up to feed people. They did not sit with people and talk with them or always explain what they were eating. However, we observed one staff member supporting two people in the ground floor dining room who explained to them what the meal was.

One person had a plate of pureed food and needed full assistance to eat. The staff initially stood and then sat on a stool next to them. The person had their eyes shut and the staff member started to put food to the person's mouth. The staff did not speak to them or explain they were going to assist them to eat. When the person did not open their mouth the staff member repeatedly tapped the person's lips with a metal desert spoon of food. The person's eye's remained shut and the only words the staff said were, "Open your mouth" and "Open". After each mouthful of food the staff member scraped the excess food from around the person's mouth with the metal desert spoon rather than using a napkin or wipe. Periodically the staff member got up without any explanation or conversation and went to support another person with their meal. This meant this person was not supported to eat and drink in appropriate way. We later observed another member of staff supporting the same person to eat yoghurt with a small flexible plastic spoon. They explained that the person found it much more comfortable to eat with the smaller flexible spoon.

Another member of staff told us another person, who was cared for in bed in the lower basement, was sometimes reluctant to eat. When we asked how they supported this person to eat, the staff told us, "We start to feed, we talk with her and we push food against her lips to get her to eat". They also said the person was, "A little difficult because she's afraid of everything". This meant this person was not supported to eat and drink in appropriate way.

People were not supported to eat and drink as directed by in their safe swallow plans written by their speech and language therapists (SALT). For example, one person's plan included they needed to have fluids from a teaspoon and we observed staff giving them fluids from a beaker.

Another person had a safe swallow plan in place that detailed their fluids must be thickened to a syrup consistency and foods must be pre mashed with no sandwiches or boiled sweets. This information was next to the food and fluids and food records in the person's bedroom. Their food and fluid records detailed they were being given sandwiches most days. We also observed staff giving this person a sandwich. We checked the person's fluids that were in their bedroom and they were not thickened to a syrup consistency. We asked a staff member if they added anything to thicken the fluids. They had limited English skills and were not able to understand us. This meant this person was placed at risk of choking and aspiration because they were not having thickened fluids and the right consistency of food as directed in their safe swallow plan.

We reviewed the food and fluid records for eight people. Most records did not include a target amount of fluids. In addition, the amounts of fluids recorded had not been totalled or reviewed to make sure these people had received enough fluids to keep them hydrated. Staff and managers confirmed that there was not any way of monitoring who was not having sufficient fluids and what action needed to be taken to increase these people's fluid intake. This placed these people at risk of harm because they were not receiving the fluids they needed to meet their needs. The risk of dehydration to these people were not being managed or mitigated.

Inadequate

Is the service effective?

In the lower basement drinks and snacks were not available at all times as it was on the ground floor. In the lower basement staff regularly gave people drinks and fruit but they did not have free access to snacks and drinks that they could help themselves to when they wanted them. This was particularly important for the people who were very active and liked to walk around the lower basement who needed to increase their food intake. For example, one person who was very active had lost 4.5 kgs in weight in six weeks. The nutritional assessment in place identified them as at high risk of malnutrition. The assessment and care plan had been reviewed on 10 July 2015 and included, '[the person] losing weight but it is not significant'. However, this person had lost 1.7 kg in ten days. No records of food or fluids had been recorded since 10 July 2015. The records that were in place did not include a target amount of fluids and had not been totalled or reviewed to check whether they had drank enough. This meant staff could not be sure what this person and eaten and drank and this was important because they were losing weight. This person's nutritional and hydration needs were not being met.

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

Coloured crockery was used throughout the home. This was good practice and research has shown that people living with dementia can see food more easily on coloured crockery and may subsequently eat more.

Most people's day to day health needs were met. We saw examples of where people had been referred to the GP, district nurses and dieticians. However, some people's healthcare needs were not effectively met. For example, one person was receiving end of life care and was cared for in bed. Their records kept in their bedroom showed that for nine different days they had a pressure area on their right heel. None of their other care records made any references to any pressure areas or whether the district nurses had been contacted. The management team were not aware of this person having any pressure areas. They checked this person's skin and confirmed with us that they had a red area on their left heel not their right as records indicated. We spoke with the visiting district nurse the following day and they confirmed the person had a pressure area on their left heel that may have been caused by them not being repositioned regularly. They told us they had not been made aware of this person's pressure area until that morning.

Another person's well-being and mental health had deteriorated. Two health and social care professionals were visiting the person. They had both been involved with the person prior to them moving into the home. They raised concerns with us that the staff at the home had not contacted them when the person's mental health and behaviour had changed.

On the first day of inspection this person was lying in their bed with their shoes on under the sheet. They were anxious, distressed and complaining of pain in their back. This person calmed when we sat and talked with them. They had a large area of fading bruising over their eyes nose and cheek bones and a dried cut to their right cheekbone. They also had a wound on their left leg that had a dressing on it. The records showed this person had a number of falls and sustained a head injury as a result of one of these falls. However, no medical attention was sought for this head injury. The management team told us and the care plan and the procedures included that medical attention must be sought for head injuries. The GP visited the following day but no records were made of the person's injuries until two days later. The daily records completed before this did not detail the injury the person's leg or who had applied the dressing or when it was due to be changed. The management team were not able to establish from the records or from talking with other staff when these injuries were sustained and when and who had applied the dressing.

The following morning this person told us they were still in pain in their back. A deputy manager told us the GP had visited two days earlier and prescribed cream for this person's pain. This GP visit was not recorded anywhere and there was not any pain management plan in place. The daily records and handover records prior to that day did not reflect that this person had been complaining from pain. The deputy manager was not able to explain what prompted them to call the GP. The records showed a few weeks before the GP was called for a related health problem. There was no record of action taken following this GP visit or any care plan put in place. We requested the GP be called to see this person in relation to their pain management.

Inadequate

Is the service effective?

Two people told us they were in pain and one person said, "I hurt on my hip". People who had pain from health conditions did not routinely have their pain assessed using a recognised pain assessment tool. These tools are used to assess people's pain levels if they cannot verbalise if they are in pain. People living with dementia may not always be able to say or show when they are in pain. This was supported by staff who told us that one person's ability to say whether they were in pain depended on how well they were and their mental capacity at that time.

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

Staff did not receive adequate supervision, appraisal and training to enable them to fulfil their roles effectively. Three staff told us they felt supported by the management team. However, the acting manager, deputy managers and all the other staff we spoke with told us they did not have a one to one support session with their line manager. One staff member who had started work a month before the inspection had not had any one to one review or support sessions to review their performance. Other staff we spoke with had limited English skills and did not understand our questions about one to one support sessions.

The most recently recruited care staff told us they were recruited through an agency and on their arrival into the United Kingdom they completed a week induction programme before starting work at the home. They told us they worked alongside other staff for the first week at the home and received an induction into working at the home.

Staff completed some core training, for example, infection control, moving and handling, fire safety, health and safety and food hygiene. The deputy manager sent us the training overview record but this did not include all of the staff who worked at the home. Ten of the 26 staff on the record had not completed any safeguarding adults training at the home. The home is a specialist dementia care home and five of the 26 staff had not completed any dementia training. From our observations, and discussions with people, staff and relatives, we found the staff did not have the skills and knowledge in dementia care to be able to meet people's physical, social and emotional needs.

The training overview record included that the five most recently recruited staff were completing the care certificate, which is a nationally recognised induction qualification. However, it was not evident who was assessing the staff completing the care certificate. One staff member told us they had not yet looked through this, as they were finding it hard because they were working both days and nights.

The shortfalls in ensuring staff received appropriate support, training, professional development, supervision and appraisal were a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspections in October 2014 and March 2015 we identified the premises were not suitable for people living with dementia. We reported at both inspections that improvements could be made with respect to signage in the home so people could identify and recognise toilets, bathrooms and bedrooms. There was also nothing on bedroom doors to make it easier for each individual to recognise their own bedroom. At the July 2015 inspection approximately half of the bedroom doors still did not have any signage on including people's names. This meant people were not able to recognise their own bedrooms.

The nearest toilet to the main ground floor lounge was locked during the inspection. The door had signage on it to show that it was a toilet. We observed people trying the door and walking off. We asked staff about why this toilet was locked and they told us the registered provider had requested the toilet be kept locked. They said this was so it could be kept clean and used for visitors. Staff told us that if people needed to use the toilet when they were in the lounge they had to use the toilet in their bedrooms or in the communal bathroom at the end of the corridor.

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

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

The service was not fully meeting the requirements of the Mental Capacity Act 2005. Staff were not fully aware of the Mental Capacity Act 2005, making best interest decisions, or who had Deprivation of Liberty Safeguards (DoLS)

Is the service effective?

applied for or authorised. One member of staff was able to explain how they sought the consent of people but other staff had limited English skills and did not fully understand our questions in relation to consent and choices for people.

For most people whose records we looked at, capacity assessments had been completed so specific decisions could be made in people's best interests. However, this was not consistent and some decisions had not been in accordance with the Mental Capacity Act 2005. For example, one person had bed rails in place. There was no mental capacity assessment or best interest decision recorded anywhere in the person's care records about using bed rails. Another person was having their medicines covertly; this meant the person was not aware they were taking medicines, for example in a drink or food. A mental capacity assessment and best interest decision was recorded and the written agreement of the GP was recorded. However, it was not clear whether the other people and professionals who were listed on the documentation were present at the best interest meeting or whether they had been consulted and agreed to the best interest decision. For a third person, documents relating to consent had not been signed by the person or their representative or relevant person.

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

The DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. Some of the people living at the service had been assessed as lacking mental capacity due to them living with dementia. DoLS applications were completed and submitted to the local authority. However, the management team did not have robust system for reviewing when people's DoLS authorisations were expiring and/or taking action if people's mental capacity improved and they could make decisions about where they lived. This meant that some people may have been subject to DoLS when this was not needed. This was an area for improvement.

Inadequate

Is the service caring?

Our findings

The management team told us one person was receiving 'End of Life' care. On the first day of the inspection this person was accommodated on the second floor. There were no other people on the second floor during the day and no staff were based there during the day or night. This person had no stimulation and did not have anything to look at, or hold or listen to. This person was not able to reposition themselves and was lying looking at either bed rails or the ceiling for two hours at a time. The way their bed was positioned they could not see out of the window. Three staff worked on the first floor during the day and they told us were responsible for checking on this person alongside the six people cared for in bed on the first floor. The person's 'End of Life' care plan in place specified that staff were to check on them every half an hour. Staff confirmed this was how often they checked the person. We observed and the records showed this person was not checked every half an hour as detailed in their care plan. We raised our serious concerns about the care this person was receiving and the staff made the decision to move this person to a vacant bedroom on the first floor. However, they had not identified this prior to us raising the concerns. The next day the person had been moved to a bedroom on the first floor so they could have more stimulation and observation from staff. They had the radio on when we visited them and had been positioned so they could see out of the window. However, the records still showed the person was not being checked every half an hour as detailed in their care plan.

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

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, who were able to walk independently, moved freely about the floor they were living on. However, as previously identified people in the lower basement were not supported to access the outside spaces even though it was warm and sunny during the inspection.

Not all of the staff were caring in their approach to people. Some staff did not smile at people or reassure them when they were upset or worried about things. We did not see staff laughing with people or encouraging them to interact with each other or themselves. Some people were observed to be withdrawn and their mood was neither happy nor sad. People's mood did not change when staff interacted with them. People usually respond positively and their mood and well-being improves when they have good interactions with staff.

Not all staff responded or acknowledged people when they called out and they did not go and sit or talk with them, particularly in the lower basement. Some of this lack of response was because there were not enough skilled staff to meet people's needs. When one person repeatedly called out from their bed and staff ignored them, we went and sat and talked with them until they settled. This meant people were not treated with respect and they did not receive the care and support they needed.

Some people's privacy and dignity was maintained. Most staff knocked and asked permission before entering people's bedrooms. Privacy screens were used on the ground floor when people were hoisted. We observed one person on the ground floor lounge who had their skirt pulled up exposing their upper legs. Staff noticed this and pulled down their skirt but they only pulled it down on one side and this left one leg fully exposed. This person's dignity was not maintained.

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

Two relatives told us they visited the home every afternoon to visit their spouses. Following the inspection we were contacted by a relative who told us they were asked only to visit during the hours of 2pm and 4pm and to avoid mealtimes. This concern was previously identified in our October 2014 inspection. This was an area for improvement and visitors should be free to visit at any reasonable time.

One person and two relatives we spoke with were positive about the care they and their relatives received. Some people smiled and chatted with some the staff they had

Inadequate

Is the service caring?

known over a longer period of time. Staff who had worked at the home for a number of months spoke fondly of the people they supported and cared for. Most of these staff were warm and friendly in their approach to people.

Inadequate

Is the service responsive?

Our findings

In the ground floor lounge staff played ball and skittle games with people. Music was playing quietly in the background and one member of staff played a game of ludo with three people. We saw that one person was holding a soft toy for comfort and was talking with it. People were observed to tap and sing along to the music. In the lower basement people the radio was on a local pop station and people did not react or sing along to the songs. This was possibly because they did not recognise the music. People had interactive puzzles placed in front of them with no explanation of what to do with it from staff. Staff did not engage people in activities such as setting or laying tables or activities of daily living. There was nothing for people to pick up and do to keep them interested and occupied based on their individual needs and interests.

Four of the people who were cared for in bed had no stimulation, music, things to look at or touch to occupy them. Three of these people needed staff to reposition them and they spent at least two hours in the same position looking at a blank wall or ceiling without any stimulation or anything to listen to or watch. None of the people who were cared for in their bedrooms had a care plan in place to instruct and guide staff as to how to provide any stimulation and occupation for them.

Some but not all people had life histories and information recorded about what was and had been important to them. However, staff were not aware of this information. They did not understand the importance of people's preferences and past experiences in planning and delivering care to meet their well-being needs.

Visiting health and social care professionals and a district nurse raised concerns about the lack of stimulation and activities for people, particularly those who were cared for in their bedrooms.

People's needs were not fully assessed and planned for to make sure that the staff at the home could meet their needs. For example, one of the directors of the registered provider had completed an assessment of one person whilst they were in hospital. This assessment was not signed or dated. The acting manager and staff confirmed they had not met this person until they arrived in the home and had to complete their care plan once they had been admitted into the home. This person had epilepsy and as previously identified in the 'safe' section of the report there was no description of how they presented when they were having a seizure or any plan of what action staff needed to take if they were having a seizure. Daily records included that the person was distressed because the bed rails were up and they couldn't get out of bed. The bed rails risk assessment and plan in place included contradictory information as to whether the person wanted the bed rails to be used. This meant this person's need were not fully assessed to establish whether staff could meet their needs and staff did not have all of the information they needed to be able to safely care for them.

Another person was admitted into the home in June 2015. A senior staff member told us that an assessment of needs had not been completed by anyone. There was no record of an assessment in this person's records. There some basic information that the person's family had completed after their admission into the home.

A third person was admitted into the home in June 2015. This person's assessment was completed by one of the directors of the registered provider, and not by staff at the home to establish whether they could meet the person's needs.

We also identified concerns about a service user being in admitted into the home without an assessment at a previous inspection in January 2015.

We saw that some relatives had signed people's care plans to indicate they had been involved in the care planning, but this was not consistent. As previously identified in the 'effective' section of the report, people and or their relatives were not consistently consulted or involved in developing people's care plans. Relatives of two people were not consulted as relevant persons, and were not enabled and supported to participate in making decisions or managing their relatives care or treatment. One relative told us that they had not been consulted about the person's care needs, their likes and dislikes commenting, "They have never asked me questions about him". This was supported by the lack of initial assessment completed by staff working at the home. Another relative had raised concerns that their relative's bedroom had been moved without them being consulted. Staff confirmed that they had moved this person's bedroom because the bedroom was too hot. This meant the service failed to involve relevant persons in decisions relating to people's care and treatment.

Inadequate

Is the service responsive?

Overall, peoples' basic and personal care needs were planned for but the care was not provided as planned to some people. For example, we waited outside the bedroom of the person who was receiving end of life care, whilst one staff member repositioned the person. The person's care plan detailed that two staff were to use a slide sheet (a piece of moving and handling equipment) to reposition the person. The management team and staff confirmed that two staff were needed to reposition this person. However the equipment needed was not in their bedroom and only one member of staff supported them with this repositioning. This meant that staff did not provide the care to this person that had been planned to meet their needs.

Later that morning this person was leaning up against the bed rail with their head in an awkward position. We could not locate a call bell in the bedroom to summon assistance so we had to leave the person to find a staff member. We found a staff member on the ground floor who accompanied us to the person's bedroom on the second floor. They also could not locate a call bell to call for staff assistance. They asked us to stay with the person whilst they found two other staff to reposition the person. This meant visiting relatives, professionals and staff did not have any means of calling for assistance for person, and staff were not able to respond to the needs of this person.

Another person's teeth were stained and covered in brown food debris on two days of the inspection. Their oral care plan detailed that staff needed to clean the person's teeth twice a day and give full assistance with this. The person was not able to tell us if they had their teeth cleaned because they were living with dementia. We checked all of the care records and none of them made any reference as to whether their teeth were cleaned. The staff working with the person did not have English as their first language and did not fully understand the questions we asked them about the person and their care needs. This meant this person did not receive the care that was planned to meet their needs.

Some people's hair was unkempt, long and not styled. One person's care plan included information from their relatives about how important the person's appearance was. This meant this person's preferences and their assessed needs were not being met.

Staff responded promptly when we used the call bells to seek assistance for people. One person said that staff, "Come fairly quickly". However, during the inspection three people did not have access to a call bell. One person did not have access to their call bell on 13 and 14 July 2015. This person was unsettled and distressed on both days. We had already identified with both the management team and other staff that this person did not have access to their call bell on 13 July 2015. However, this did not lead to staff making sure they had access to their call bell on the second day of the inspection. As previously identified in the 'safe' section of the report one person experienced delays of up to 14 minutes before their call bell responded to. This meant staff were not able to respond to people's needs because the people, visitors or staff did not have the means to seek assistance.

These shortfalls were a breach of Regulation 9 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This because these people were not receiving the social stimulation and care and support they needed to meet their care, support and emotional well-being needs. In addition, people's needs had not been assessed and care plans had not been put in place or they had not been followed.

Complaints information was available in the main foyer of the home. The two relatives told us they were aware of how they could make a complaint. We reviewed the complaints received since the last inspection in March 2015. As previously identified two of the complaints included allegations of abuse and no action had been taken in response to one of these. The remaining complaints had been investigated by the management team and the actions planned were recorded. However, there was no formal written feedback provided to people who raised complaint. In addition to this, there was also no system established for how actions were to be implemented and who was responsible. For example, one of the actions identified in response to one complaint in May 2015 was that a family member would be informed of their relative's weight each week. It was not clear who or how this was going to happen. There was not any system for sharing learning from complaints with staff. This meant the complaints systems were not operated effectively.

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

Inadequate

Is the service well-led?

Our findings

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

Staff gave us conflicting information as to who they thought was the acting manager, and responsible for the home. The acting manager initially told us, that they were appointed by the management consultants (appointed by the registered provider) and they were the acting manager of the home. They later told us they were appointed by the registered provider not the management consultants. The other senior staff were not made aware of this. The registered provider did not notify us of the new management arrangements in place from May 2015. This lack of openness and transparency about the responsibilities and management arrangements at the home contributed to the lack of systems or processes being established and operated effectively to ensure the home was well-led.

Senior staff told us that the management consultants appointed by the registered provider had visited the service twice in the two weeks prior to the inspection to undertake some audits including what they believed they were medicines audits. The management team told us they did not receive any verbal or written feedback from these visits or audits to identify any areas for improvement. We requested other internal audit information from the acting manager and this was not provided. Two senior staff told us and showed us that they had completed medicine audits on a monthly basis. They had completed audits for the medicines they were each responsible for ordering and administering. This meant that the audits were not an independent check of medicine management. The audits had not been effective in identifying the shortfalls identified in this notice.

Concerns about call bell response times were raised via a safeguarding investigation. A senior member of staff told us they did not use any system for checking call bell response times, and that they were not monitored.

The acting manager and senior staff told us they were not responsible for the recruitment of staff. The acting manager told us they had interviewed one person and recruited them. However, all of the other staff were recruited by two of the directors of the registered provider through a recruitment agency. The acting manager and staff told us that new staff had turned up at the front door with a suitcase, to start work and were accommodated in the vacant service user bedrooms in the home. Senior staff told us the most recently recruited staff did not have English as their first language and they were concerned that limited understanding of verbal and written English placed people at risk.

The findings throughout the inspection showed there was a failure to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk. In addition, there was a failure to assess, monitor and improve the quality and safety of the services provided. This is because the arrangements and staff responsible and delegated to the day to day management of home did not have full oversight and responsibility for the quality and safety of the service. There was not any clarity as to who had overall responsibility for the management of the service.

Accidents, incidents, safeguarding and complaints were not routinely monitored, reviewed and used to improve the quality of care or safety of the service provided to people. As detailed in this report, accidents, incidents, safeguarding concerns and complaints were not followed up or action taken in response. There was a failure to ensure risks were identified, monitored or mitigated to ensure people's health, safety and welfare.

Survey questionnaires were in the Quality Assurance file but these were not dated and were not analysed to identify any areas for improvements.

The management team held a meeting in April 2015 with nine people's relatives and also held a residents meeting in February 2015. This showed that efforts were being made to consult, involve and communicate with people and relatives. Actions were identified in the meeting minutes but it was not clear how this information was communicated to relatives or people who did not attend the meetings. The minutes of these meeting were not displayed so that other people and relatives had access to them. Not all the actions from the meetings had been implemented. For example, people had been asked about

Inadequate

Is the service well-led?

the activities they would like to do but the activities had not been provided. This meant there was a failure to act on feedback from people and relevant persons to continually evaluate and improve services.

The registered provider did not check whether the systems in place for monitoring, assessing and improving the quality of the service were effective. This failure to assess and monitor the service meant the registered provider was not aware of the shortfalls in the safety, health and welfare of people and the governance of the home.

Three staff told us they felt well supported by the management team and they could approach them with anything and they would take action to address any matters raised. However, this contradicted our findings throughout the inspection.

Some staff knew how to raise concerns and had a basic understanding of whistleblowing. However, the acting manager was not confident that staff were raising all of their concerns. This was supported by our conversations with staff. There were policies in place for staff but these were kept in the office and were not readily accessible.

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

On 14 July 2015 we saw people's cream MAR records and accident records from the previous month on the front desk visible to visitors. In addition, people's personal information and medical information was recorded in the main diary. This meant that the information could be seen by other people, was not stored securely and there was not a contemporaneous record for these people.

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. Some people's records had unexplained gaps between recordings. Records for two people did not reflect what action had been taken in relation to their skin damage from pressure areas, medical conditions and falls. Records were not accurate and we noted that some records did not reflect our observations. For example, one person's records detailed they were sat up but we observed they were lying on their left side. This person was not able to reposition themselves because of their physical frailty. Fluid monitoring records and body maps for people were not fully completed, totalled and reviewed as prompted by the documentation.

These shortfalls in record keeping were a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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 9 HSCA (RA) Regulations 2014 Person-centred care People's care and treatment was not appropriate and did not meet their needs or reflect their preferences.

The enforcement action we took:
We have imposed an urgent condition on the provider's registration. This means further people cannot move into the home or return from hospital without our agreement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way.

The enforcement action we took:
We have imposed an urgent condition on the provider's registration. This means further people cannot move into the home or return from hospital without our agreement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not being met.

The enforcement action we took:
We have imposed an urgent condition on the provider's registration. This means further people cannot move into the home or return from hospital without our agreement.