# Tracs Limited

# Highbridge Court

**Inspection report**

25 Berrow Road,
Burnham-on-Sea,
TA8 2EY
Tel:
Website:

Date of inspection visit: 29 January, 01 February and 04 February 2016
Date of publication: 19/05/2016

## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Requires improvement** |
| Is the service safe? | **Requires improvement** |
| Is the service effective? | **Requires improvement** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Requires improvement** |
| Is the service well-led? | **Requires improvement** |

## Overall summary

This inspection was unannounced and took place on 29 January 2016, 1 February and 4 February 2016.

Highbridge Court is a care home providing accommodation for up to nine people with mental health needs. At the time of our inspection, four people were living in the home.

There wasn't a registered manager; however there was a manager in post who was going through the registration process with CQC. 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 the last inspection on 16 and 17 July 2015 Highbridge Court was breaching five regulations of the Health and Social Care Act 2008.

1. Safe care and treatment (Regulation 12). We saw partial improvements had been made.
2. Safeguarding service users from abuse and improper treatments (Regulation 13). The required improvements had been made.

# Summary of findings

3. Staffing (Regulation 18). The required improvements had been made.
4. Need for consent (Regulation 11). We saw partial improvements had been made.
5. Good governance (Regulation 17). We saw partial improvements had been made.

Although there were systems to assess the quality of the service provided in the home, we found some of these were not effective. The systems had not ensured that people were protected against some key risks, such as unsafe practices around medicines. The amounts of medicines that were recorded as being in stock were not always the same as the actual medicine in stock.

Staff were not consistently recording information about people's food and fluid intake where food and fluid charts were used. People's mental health needs may not be fully supported because care plans had gaps in records for mental health relapse monitoring.

Staff had been provided with a range of specialist mental health training such as autism and schizophrenia. Staff felt the training they received gave them the skills they needed to be able to provide the necessary support for people.

Although a senior clinical lead had identified some people may lack capacity at certain times, care plans had not been updated with this information. There was no guidance for staff how to recognise when people may have reduced capacity. There were no records of best interest meetings being held where people lacked capacity to make decisions.

People were protected from the risks of abuse because staff knew how to recognise abuse and how to respond appropriately. Staff were aware of procedures to escalate concerns to the local authority if necessary.

People were supported to access a range of activities in the community. Activities were arranged on an individual basis according to people's needs and wishes.

We found repeat breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking further action in relation to this provider and will report on this when it is completed.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires improvement 

The service was not always safe.

People's medicines were not well managed and medicine audits had not identified this.

People's mental health needs were not fully supported because there were gaps in records which identified if people's behaviours were stable or deteriorating.

People's risk assessments did not always identify risks or give staff the information they needed to be able to provide support for people safely.

Staff had not completed the required fire evacuation practices to support people to evacuate in the event of an emergency.

**Is the service effective?**

Requires improvement 

The service was not always effective.

Staff were not always following guidance in care plans and were not recording people's intake of food and fluids where these were identified as being necessary.

Staff had been provided with a range of clinical training to help them meet the needs of people they supported.

Although staff were aware of the Mental Capacity Act 2005, they did not have information about people's capacity to support people to make decisions.

**Is the service caring?**

Good 

The service was caring.

People felt staff respected their privacy and dignity. People's confidentiality was respected.

People were supported to express their views and preferences. People were able to be actively involved in activities which were important to them.

People were able to access an advocacy service if they wished.

**Is the service responsive?**

Requires improvement 

The service was not always responsive.

People were not supported to maintain relationships with families who lived abroad where they had requested staff support with this.

People were able to contribute to the planning of their care.

People were given information about how to make a complaint. The provider had not acted promptly to resolve one complaint.

# Summary of findings

**Is the service well-led?**

The service was not always well-led.

Systems to assess the quality of service to people had not picked up on the shortfalls that we found. There were no systems in place to ensure audits were completed if staff designated to do the audits were absent.

Although staff had taken part in meetings recently, there were no minutes of these. As there were no records of what had been discussed or any actions that needed to be carried out, it was not possible to check if any agreed changes had been made.

People were supported by a staff team who told us the manager was approachable and supportive.

**Requires improvement**

# Highbridge Court

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 29 January 2016, 1 February and 4 February 2016. The first two days were unannounced. It was carried out by an adult social care inspector who attended all three days and two other inspectors who attended one day each.

Before the inspection we reviewed information we held about the home, including notifications about important events which staff had sent to us. We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Instead, during the inspection, the registered manager provided us with a range of documents, such as copies of internal audits for the home's décor and finances and action plans, which gave us key information about the service and any planned improvements.

We spoke with three people who used the service. We spent time observing the way staff interacted with people and looked at the records relating to care and decision making for four people. We spoke with the manager, area manager and eight care staff. We looked at four staff files. We looked at records about the management of the service. Three healthcare professionals provided information after the inspection.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Requires improvement

# Is the service safe?

## Our findings

During the inspection in July 2015 we found where risks had been identified there was either limited or no information on how to reduce the risk. Where incidents had occurred involving individual people living in the home, no action had been taken to reduce the risk of reoccurrence. Although staff were knowledgeable in recognising signs of potential abuse, some staff were unaware of the relevant procedures for reporting to the local authority. During this inspection, we found things had partially improved.

During this inspection, we found people were not always safe because medicines were not well managed. The amount of medicine recorded was not always the same as the actual medicine in stock. For example, one medicine was 38 sachets overstocked. We asked the manager to discuss with one person's G.P. whether they should have a blood test; this was arranged. This was because the medicine could cause harm if the person had taken too much. This person also had a box of 28 tablets that was not accounted for on their medicine records. The manager told us the extra box should have been returned because the way the person took this medicine had changed. This meant the provider could not ensure people were given the correct amounts of medicine and their health could be at risk. When made aware of our findings, the manager responded immediately and excess medicines were logged in the returns book and returned to the pharmacy. Discontinued medicines had not been returned to the pharmacy; these were returned during the inspection with the excess medicines. Medicine errors were logged where medicines stocks had been identified as incorrect and medicines missing that were not accounted for. The provider took action as a result of our findings and the medicine administration records (MAR charts) were amended to reflect the correct stock levels. During the inspection, the manager arranged for stock levels to be counted twice daily, so any errors would be identified immediately. The manager assured us this twice daily check would continue after the inspection. An analysis of the reasons why medicine stocks were incorrect was going to take place. We have asked the provider to tell us the results of this investigation when it is complete.

Boots Pharmacy completed an audit in January 2016; their report concluded there were no issues in relation to policies and systems for managing medicines, ordering and receipt of medication, the storage of medication, the disposal of medication, the administration of medication and in relation to the care home's staff training. The audit gave the following advice; "Make sure all stock is carried forward for better audit trail", "Make sure internal and external (medicines) are stored in separate areas of the cupboard", "Make sure the date opened is recorded on all creams" and "Make sure there are two staff signatures for all the handwritten entries." The manager assured us they would be implementing the recommendations.

We saw the medicine administration records for each person. Medicine administration records (MARs) were completed in full. The MARs we looked at had all been signed and there were no gaps which indicated that people had received all of their medicines as prescribed. One member of staff said the shift leader was responsible for checking that the MARs had been completed in full at the end of their shifts. We looked at the daily planner which stated "Shift Leader to check MARs". However, these had not been completed in full. For example, on four dates in January 2016 staff had not ticked to indicate they had undertaken the check. There was also a section on the form for staff to initial that they had given people their medicines. Again, this was not consistently being completed by staff. On four dates in January 2016 and two dates in February 2016 staff had not initialled the form. This meant the checks that were in place to ensure all medicines were administered and signed for were not always being completed, and therefore if any medicines had been missed this would not have been picked up

There was no medicine identification sheet with a photograph to identify one person. The home's own audit conducted after we raised our concerns identified one person needed a medicine identification sheet, though previous audits had not identified this issue. This meant the home was not following the organisations own requirements to have medicine identification sheets in place to ensure the correct medicine was given to each person. The area manager checked the medicines file and identified weekly stock checks had not been completed for two weeks. The manager said a senior member of staff responsible for the medication audits was on annual leave. This meant there was no system in place to ensure audits were still completed when designated staff were absent and therefore any errors would not be picked up.

Requires improvement

# Is the service safe?

There were records for medicines that were not required on a daily basis. People said, "They'll give me pain relief if I need it. Most staff are trained, but when you get agency staff mixing in with full time staff you have to make sure you've got your painkillers before they go." This meant although there was always trained staff on duty who could give people pain relief, people were unsure whether they would be able to have pain relief when they needed it.

Most medicines were stored safely and in line with relevant regulations and guidance. One person was self-administering their medicines and kept them within a locked cupboard in their room. A member of staff said the person had been assessed as competent to do this, and we saw the supporting risk assessment was in place. The process for assessing people as competent to self-administer medicines was effective. The cupboard where the person's medicines were normally stored had a thermometer inside and staff said the person was responsible for checking the temperature daily. Staff also checked the temperature and there was a temperature log in place. However, the log stated that the maximum temperature should not be above 25 degrees centigrade and the log showed that on six days in January the temperature was recorded as being above 25 degrees. Although staff told us the pharmacist had been asked for advice, nothing had been documented. No action had been taken to address this problem, which meant the person's medicines had not been stored safely.

Because some of the medicines people were prescribed were essential to their mental health and wellbeing, it was important that they were administered on time. One person had refused their medicines on occasions which staff had identified was a risk to their health. The person's care plan gave clear guidance to staff on how to deal with this issue should it arise. The guidance informed staff to "Remind of the consequences of not taking prescribed medication and how it will affect well-being". The plan informed staff to ask the person every 15 minutes, but if they continued to refuse for an hour after the prescribed time, then it should be recorded as a missed dose. Staff were also advised to inform the mental health team, as well as report the incident internally. The plan also informed staff to contact NHS Direct for advice in relation to missed doses. The person's care records showed that on one day in November 2015, staff had documented that they rang 111 for advice as per the plan. However, although they had documented that they had asked for advice, the detail of the advice they were given was not recorded. This meant the advice given was not available for all staff.

In-house medicines training was provided, which was in line with the provider's medicines policy. We saw copies of the provider's Internal Medication Training booklet that showed the content of the internal training that staff received. This was in-depth and comprised of questions and scenarios for staff to complete.

The medicines policy stated, and staff confirmed, their medicines training included five competency assessments. Competency assessments are observations of staff giving out medicines to make sure they are safe. Of the nine members of staff who were administering medicines, five did not have signed competency assessments in place. This list of nine staff included one member of staff temporarily allocated to the home. Although the manager assured us that staff had been assessed as competent, they were unable to locate the missing assessment forms to corroborate this.

An audit completed in November 2015 stated, "Medication competency checks have been carried out for some of the staff at the home, though not all." The area manager completed a key performance audit on 07 January 2016 and said, "Actions from the most recent audit have been closed out. No meds errors identified on medicine administration records." This meant the key performance audit had not identified whether the observations were outstanding or the records missing. This meant staff may be administering medicines without the necessary competency assessments in place and people could be at risk of mistakes happening.

When people move between services it is best practice to have a handover of their medication. This includes the quantities handed over; the person the medicines were given to; and a signature from both parties confirming the handover was complete. This ensures medicines are not lost during transfer. One person's handover of medicines did not have a record of who had received the medication and how many they had received. The manager said the medicine was taken to a different location and they should have followed up the handover documents. This meant there was no record the medicine had been delivered to the new location and the home could not show they had not lost any medicines on transfer.

Requires improvement

# Is the service safe?

Care plans contained mental health relapse monitoring charts which staff were required to complete daily. The aim of these records was to prevent or lessen a mental health relapse by identifying whether people's behaviours were stable or deteriorating. Three care plans had gaps in these records. This meant if someone's mental health was deteriorating, people's mental health needs may not be fully supported because the deterioration was not fully recorded.

Where risks had been identified there were some risk assessments with either limited or no information on how to reduce the risk. One person's risk assessment for kitchen access and food hygiene did not identify issues which were recorded in the brief summary of the person. We asked staff if there were any risk assessments for people around food and meals. One member of staff said, "I'm not aware of any risks, only for one person who eats too much." This meant staff were not aware of the risks relating to access to food that could cause increased anxiety. There was no guidance for staff how to support this person if they became agitated. We asked a senior manager to find information for staff about managing this person's aggressive behaviour in their care plan; they agreed they could not find it. We fed this information back to the manager and a risk assessment was put in place for the third day of the inspection.

The provider had given us information which stated that all risk assessments had been updated; however we found they were insufficient. The area manager said, "All risk assessments have been revisited and sent to our nominated individual and CQC. We hadn't identified previously how to manage risks." We saw one risk assessment and a clinical review which had information about a different person to the care plan; this meant the documents had been put in the wrong care plan. Another risk assessment identified a person could be 'verbally abusive'. We spoke with this person and they told us what could trigger this behaviour; however, this information was not recorded in their care plan. We saw a letter in one person's care plan which identified concerns about a risk of fungal infection; however there was no risk assessment or risk management guidance for staff how to support the person with this. We saw one person's risk assessment from October 2015 which gave staff guidance in the event the person refused their medicines; however, this person was no longer taking medicines so the assessment had not been updated. This meant some risk assessments contained the wrong information, out of date information or did not contain the information staff needed to be able to provide support to meet people's needs.

The manager told us, "All of the risk assessments have been updated. They are evaluated monthly." We asked staff if they had read risk assessment information, they told us, "I was told people's diagnoses and I saw the care plans." Staff were able to tell us information such as medical treatment and activities people liked to do, but could only tell us limited information about risk assessments. One member of staff said, "I'm aware of some risk assessments but not sure." The manager told us, "A read and sign system is used to make staff aware." One carer told us, "I'm aware of the risk assessment which identifies risks to others." We asked how they would deal with this and the strategy they described was not in this person's care plan.

We asked staff how they would deal with any emergencies that arose and they were able to describe what actions they would take. However, there were no records of fire practices practice drills being carried out. Staff said, "I've never been here when there's been a fire practice." The area manager's key performance audit identified the last fire evacuation was held on 24 September 2015 and stated this was overdue and required as soon as possible. This meant people were at risk because the required fire practices were not being carried out."

When we looked at personal emergency evacuation plans on the second day of the inspection the information did not fully reflect people's needs. For example, staff told us, "[Name] may ignore the fire alarm due to agitation to noise" and for another person, "His evacuation plan doesn't match his needs." We saw an emergency evacuation plan which did not identify another person needed support to evacuate because they had reduced mobility. However, staff we spoke with were aware of this. Staff said, "I'm aware of one person who would need support to evacuate due to their poor hearing and mobility issues." We fed this information back to the manager. The documents were updated by the third day of the inspection and contained detailed information how staff should support people. We saw the grab file had been updated with information about people's contacts, medicines and places of safety should everyone need to be temporarily housed elsewhere. The fire risk assessment was updated

# Is the service safe?

the day before the inspection with seven significant findings and the actions that need to be taken. These actions were due to be completed at the end of February 2016.

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

Some people using the service were receiving medicines that required regular blood tests to ensure the dosing was appropriate. Care plan records showed that the monitoring had taken place and that people had attended the GP surgery for regular blood tests when necessary. Staff said that if they had any concerns in relation to people's medicines, such as changes in behaviour, mood or reactions, they contacted either the GP for advice or the person's mental health team. Records showed that advice had been sought in these situations. One person was prescribed an anticoagulant (blood thinning medicine) which requires regular blood testing to ensure the correct dose is prescribed. We saw the person was monitored by the GP surgery and that the results of blood tests were logged and available for staff. Certain drinks need to be avoided when receiving this medicine and this was clearly documented in the person's support file.

Risks of abuse to people were minimised because there was an effective recruitment procedure for new staff. This included carrying out checks to make sure they were safe to work with vulnerable adults. Where gaps had previously been identified in staff files, these had been addressed. We looked at the recruitment records for four members of staff. These showed the provider had carried out interviews, obtained references and a full employment history and carried out a Disclosure and Barring Service (DBS) check (a check on people's criminal record history and their suitability to work with vulnerable people) before they commenced employment. Staff told us they completed nine months' probation and during this time they received monthly supervisions. At the end of the nine month probation, they received an appraisal where they received feedback from everyone they worked with. Staff said, "It's brilliant because you can see where you can improve and know what people want."

People told us they felt safe at the home and with the staff who supported them. People said, "We're safe, we have carers here" and "Staff support you." Staff said, "I think people are safe because we care about their wellbeing", "We know our residents well; their abilities and what to be mindful of." Staff told us, and records seen confirmed that all staff received training in how to recognise and report abuse. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Staff said, "I'd phone the manager immediately, and phone the local authority if necessary", "I'd phone the police if it was an immediate urgency and phone the local authority if necessary" and "I would raise concerns with the manager first, then the regional manager, then phone safeguarding if necessary." The manager told us, "We have an electronic system to track safeguarding referrals." This meant the manager was able to keep track of what safeguarding referrals had been made and was able to use the information to identify areas for improvement. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected. All staff we spoke with were clear about their responsibility to escalate concerns to the local authority if necessary. Staff said, "We've got to provide care, people have the right to feel safe and protected from abuse."

People were supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner. Staffing numbers were increased by the use of agency staff and staff from other homes who already worked for the organisation. The manager told us, "We never put two agency staff on together; there is always a permanent member of staff on duty." People told us, "At this precise moment there are and are not enough staff because they go on leave or sick" and "There needs to be more staff for safety." All staff we spoke with felt there were enough staff on duty throughout the day. Staff said, "Having a sleeping night staff is fab because there's another member of staff here if anything happens" and "We've got enough staff for the number of residents." There were nine permanent members of staff and of these; three had been away on long term sick leave. At the time of the inspection, the manager said there was one full time post available and another post would shortly be vacated. The manager said, "We know it's not sustainable using agency and staff from Wales", and "We are aware of the stress this causes people and we're addressing this." The manager had taken steps to address this and was working towards increasing the staff available.

Requires improvement

# Is the service safe?

The manager used a staffing levels and skills risk assessment to determine the mix of staff required with identified skills such as challenging behaviour training, first aid, medicines and health and safety trained. We saw the staffing rotas for January 2016 and February 2016. The staffing rotas did not identify which staff had the required skills identified in the staffing risk assessment. The staff training rotas did not show which staff had completed training for dealing with challenging behaviours. This meant it was difficult for the provider to be sure the staff on duty had the skills identified as being necessary in the risk assessment.

Requires improvement

# Is the service effective?

## Our findings

During the inspection in July 2015 we found people were not always supported with staff who were suitably trained. During this inspection, we saw staff had been provided with specialist training. During the inspection in July 2015 we found there were no systems in place to assess whether people had varying degrees of capacity and consequently no processes for keeping people safe. During this inspection, we found this had not improved.

During this inspection, we found the service was not always effective because where food and fluid charts were required; staff were not recording the details of food and fluid intake. Most people were able to cook their own meals during the week and staff cooked for people at weekends. Staff said they would notice if people weren't getting enough to eat or drink. One person's care plan contained a risk assessment which stated, "Monitor when food is eaten in communal areas." We saw food and fluid charts kept for this person from 24 January 2016 to 1 February 2016. Although staff cooked for people at weekends, there was no record of what this person had eaten or drank on 30 January 2016. This meant records were not kept in line with the requirements of the risk assessment. Another person's care plan stated, "Staff ask [name] what he has eaten so staff can advise whether he has eaten healthy food or not, and whether this will impact on his diabetes. [Name] requires staff supervision of suitable diet." There were five food and fluid charts in this person's care plan, none of them contained complete information about this person's food and fluid intake for the day relating to the record. One member of staff said, "We're supposed to monitor what he eats at weekends." We saw some information in the daily records about this person's meals; however anyone wanting to see what had been eaten had to read the whole page of daily notes to find the information. This meant there was a lack of clear guidance for staff around how and where to record daily food and fluid intake. Most of the comments were, "Nothing witnessed" or "Not seen." As staff were not following the guidance in the risk assessments and were not recording people's intake of food and fluids they would not be able to monitor risks to people's health surrounding this.

There was a lack of guidance for staff around which units they should use when monitoring people's weight. We saw a weight monitoring chart for one person, where the information had been recorded in stones and pounds one week, and kilograms the following week. This meant it was not possible to easily identify whether the person had lost or gained weight.

One care plan contained conflicting information which could confuse staff who did not know the person. The care plan contained two profile sheets, each one was different. One profile did not have information about medical details, people who were important to the person and the photograph was not dated. The other profile sheet identified important people but had a different picture. This meant agency staff or new staff would know which of the profiles were up to date and relevant for this person.

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

Most staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff said, "If someone hasn't got capacity it protects people", "They're in our care; we've got a duty of care", "We see if the clients have got capacity to make decisions and are they able to have that liberty" and "If they can make decisions we have to allow them that, we can't take it away from them."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People's care records showed that the principles of the Mental Capacity Act 2005 Code of Practice had not been followed because there were no capacity assessments for assessing an individual's ability to make a particular decision. A clinical team referral dated November

Requires improvement

# Is the service effective?

2015 for one person provided guidance for their care plan to be updated to show raised or lowered blood sugar levels may affect their ability for decision making and consideration should be given to the need to assess the person's mental capacity. This information was highlighted as needing to be added to other areas of the care plan, such as the self-medicating risk assessment and the general health care plan. These documents had not been updated to include this information. Another person's notes from a clinical team referral dated October 2015 identified the person, "Displayed a lack of capacity with regard to their current level of health risk and future complications." However, the managing mental health and living skills care plans had not been updated with this information. A physical health and self-care care plan dated September 2015 had a hand written note "Add in capacity and best interest process started re obesity." There were no further updates to this and there were no records of best interest meetings being held. This meant people may be making some decisions when they didn't always have the capacity to make those decisions without support or without an assessment of their capacity at a given moment in the case of fluctuating capacity. The manager said, "We have policy guidance in place and would look at DoLS as part of someone's risk assessment if needed."

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

People received care and support from staff who had recently undergone specialist training to improve their skills and knowledge. Staff told us, and records seen confirmed that much of the training was provided by an e-learning source. Staff said, "It's better because it's done online", "I think it's quite good because it gives us more skills." and "Lots of the examples are about care of the elderly so it could be better." Although risk assessments identified some people could be aggressive, the training records given to us did not show staff had been provided with training to deal with challenging behaviours. One member of staff told us, "I've not had training for challenging behaviour, but I've had specialist training for autism, schizophrenia, Asperger's and personality disorder." However, other members of staff said, "I went away for three days and did Studio 3 training. It opened my mind to lots of things such as how to get out of hair pulling and wrist holding. I would feel confident to deal with anything people might do" and "Studio 3 training for challenging behaviour gave us the skills around low arousal techniques such as talking people down and distraction techniques." This meant the staff training records given to us during the inspection had not been updated to include training provided for managing challenging behaviours and not all staff had completed this. The provider gave us information post inspection to include the updated training records. Another member of staff said, "The clinical training was really good, especially diabetes training because we know what to look for." The area manager told us, "My main priority was to provide staff with the tools they needed; we've worked hard to make sure staff have attended home specific training."

People were supported by staff who had undergone a thorough induction programme which gave them the basic skills to care for people safely. We saw the induction content was in line with current national guidance. Staff said, "Induction was three days and it was a lot to take in. We were given a folder to complete in the first 12 weeks and had several observations throughout", "I'm still doing induction; it was two days in another home doing mandatory training and we have a booklet to work through" and "If I needed to ask something I didn't feel worried about asking. Everyone was so quick to help."

Most people who lived in the home were able to make decisions about what care or treatment they received. The manager told us, "We are involving people in care planning; staff are sitting down with people and spending time with them." The home arranged for people to see health care professionals according to their individual needs. People told us, "My blood pressure is checked, as well as my weight, ears and appointments with the dentist" and "I can see a doctor if necessary."

Staff received regular supervisions from their line manager and told us, "We discuss what's working well and anything that's needed." Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. The area manager's key performance audit conducted in January 2016 identified areas where supervisions and appraisals could be improved.

Good

# Is the service caring?

## Our findings

People said they were supported by kind and caring staff. Staff said, "I think people are happy with staff; some people want to know which staff are on duty" and "When I first came here if felt as though I'd been here a long time, everyone was friendly and helpful."

People told us their privacy was respected and all personal care was provided in private. People said, "I have a key to my room and staff also have a key. They knock before entering or ask me first 'Can I go in your room' if they're doing a room check" and "Staff respect my privacy and dignity yes. It's vital I get my painkillers so they make sure I'm awake by knocking on my door." Staff gave examples of how they maintained people's dignity and said, "We always knock on doors before putting the key in to go in" and "We don't just go into somebody's room."

One healthcare professional said, "Staff have managed very stressful situations in a very professional manner. They have kept me informed of various incidents and meetings. I have been impressed with the staff and their caring approach on my visits."

People told us they were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. Staff said, "Friends and family can come at any time."

People told us they made choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their rooms. Staff said, "We find out what's important to people by talking to them, find out how they're feeling and what they want to do" and "We ask before helping and keep an eye on their safety. We allow independence but recognise they may need support."

We saw staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. Staff said, "All files are kept locked away."

Staff told us equality and diversity was promoted by, "Giving people the chance to feel equal" and "Giving quality care that everyone deserves."

People were supported to express their views and preferences and were able to be actively involved in activities which were important to them. Activities were arranged on an individual basis according to people's needs and wishes. Some people had regular outings in the community and were able to access these independently. Staff supported other people to access activities such as attending a gym and having trips to local attractions. The home had recently purchased a Wii machine for people to play games and other board games were available.

One person had been provided with an advocate to help them communicate with professionals. An advocate is a person who can speak for people who may find it difficult to speak for themselves. This meant the home supported the person to access services outside the home to be able to have more choice and control.

During the inspection, we observed staff speaking with people in a polite and courteous way and people responded well to staff.

Requires improvement

# Is the service responsive?

## Our findings

During the inspection in July 2015 we found care plans did not always contain specific information about the support required to meet people's individual needs. During this inspection, we found the level of information much improved, though there were still some gaps.

During this inspection, we found the service was not always responsive. People were not always supported to maintain relationships. One person had asked for WiFi to be provided in their room. This person's care plan noted they had minimal contact with their family; they told us they wanted to keep in touch with other members of their family who lived in other countries, but needed the WiFi to be able to do this via Skype. The manager explained they had provided a new computer which was available for everyone to use in the main communal area of the home. They told us, "We could move the computer into the little room to give privacy, and then move it back later." We saw an advocate had written to the service in October 2015 asking why there had not been any response to the request for WiFi. We saw the manager had tried to boost the signal to be able to meet this requirement; however, at the time of the inspection, this had not been sorted out.

People were able to make choices about most aspects of their day to day lives. People received care that was sometimes responsive to their needs and personalised to their wishes and preferences. One person had raised concerns about how poor lighting and noise had adversely affected them. The lighting was improved after the person had a meeting with the regional manager in November 2015 which had resolved this issue. The person had been offered a different room which they declined to use.

Most people had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. One person told us, "I've asked to write my own care plan" and "I'm unhappy with their daily record folder because there's not enough information." We discussed this with the manager; they were in the process of obtaining more information from the person about the information their care plan should contain. We saw this person's daily records did not contain the level of detail the person wanted and the manager agreed the care plan needed more information.

Some care plans did not show that people had been involved in reviews, which meant they had not consistently recorded that people had either been involved in reviews of their care or declined to take part. People told us, "I was told I had to sign my care plan or I couldn't stay here; I was in an absolute state" and "I've not seen my care plan, but they'd show it to me if I wanted to see it." When care plans were reviewed, people told us, "They have meetings every so often to review care plans. I'm not invited but after the meeting staff ask me to do things", "I'm involved in a manner of speaking; some staff ask my opinion" and "I get chances to sit with staff and tell them what's important to me." Staff said, "Keyworkers and co-keyworkers have meetings with the person, I'm not 100% sure but monthly maybe" and "I haven't seen any records from reviews." The manager said, "We are working with staff to re-write the care plans, we get staff from another home to help staff." The area manager told us, "I've provided training for staff around the care plan paperwork. I've identified the paperwork isn't there yet; they need to be more outcome focussed."

The registered manager sought people's feedback and took action to address issues raised. One person had said, "Why don't we have questions monthly asking what we think and what we would like and staff could type it up?" We saw the manager had responded and given a questionnaire to people. The Annual Quality Report for 2015 contained results of an annual questionnaire given to people recently. This showed people felt safe, felt staff listened to them and treated them with kindness and compassion, and people felt they had a good quality of life.

Information about how to make a complaint was clearly displayed in the home. People said, "The complaints procedure doesn't tell you what to do when you want to complain about someone at the top" and "I would say something if I wasn't happy, but at this point everything's fine." We saw one person had made a complaint via an advocate in September 2015; this was still being dealt with. We raised this with the manager, who said the complaint had been documented and escalated to the regional manager. The regional manager had spoken with the person making the complaint. This meant although the home had listened to the person's complaint, they had not acted promptly to resolve the issue. Staff told us, "If someone wanted to raise a complaint I'd ask them about it and try to understand" and "There's a complaints leaflet on the board." One person raised an issue about the lack of

Requires improvement

# Is the service responsive?

space in the communal area and said, “Only six people can sit at the dining table and only five people can sit in a comfy chair and when people pace as well there’s no room. It would be totally unsuitable for more people.” Staff said, “The communal area is small, if we had more people it would be harder work but would be fun because we could do more group activities and go out together. This meant people’s concerns about the communal space available were not listened to.

Requires improvement

# Is the service well-led?

## Our findings

During the inspection in July 2015 we found although there were systems to assess the quality of the service provided in the home, these were not effective and placed people at risk of harm. The systems had not ensured that people were protected against inappropriate or unsafe care and support. The public were also at risk as a consequence. During this inspection, we found some improvements had been made.

During this inspection, we found some aspects of the service were not well led. During the inspection in July 2015 we identified gaps in risk assessments which meant staff did not have the information they needed to be able to keep people safe. On the second day of this inspection, we found some risk assessments were still not available, for example where one person hoarded food. We fed this information back to the manager and a risk assessment was put in place by the third day of the inspection. We saw one person's risk assessment indicated they may leave the home for between one and eight days. Whilst this person had been living at the home they had special conditions imposed upon them, however the risk assessment reviews done in October 2015 and December 2015 had not recorded these, instead they recorded 'no change'. The client risk management and risk assessment plan set out clear guidelines for the timescales for reviews. The document stated, "All High Alert risks should be reviewed at least weekly for the initial risk management period, all High risks should be reviewed at least monthly but may also initially require weekly review, other risk assessments should be reviewed monthly." This meant the home had not completed the reviews considered necessary as outlined in the risk management and risk assessment plan." Although the care plan did not accurately record all details, staff were aware of the conditions imposed on the person. The manager told us this person had a period of heightened anxiety; however there was no guidance in the care plan giving staff information how to support the person if this was to happen again. We fed this back to the manager and saw the care plans and risk assessments had been updated by the third day of the inspection. The service had not identified where there were shortfalls in risk assessments proactively, but instead updated risk assessment reactively, when shortfalls were pointed out to them. This meant people and staff were at risk because risk assessments did not always give staff the information they needed to be able to provide the support people required. One healthcare professional said, "I have recently seen evidence of improved risk assessments and care plans which would go some way to suggest that there are improvements being made." Another professional said, "Highbridge Court has demonstrated a good ethos of working together; this has been a good demonstration of multi-agency working."

The home's quality assurance processes had not picked up the shortfalls we found. The manager told us there had been two audits since October 2015, and there had been five audits with the previous registered manager in post; this was from September 2015. Some weekly medicine checks had not been completed and medicine audits had not identified the discrepancies between medicines in stock and on record. The regional manager told us medicines weren't checked during medicines audits, but the medicine administration records (MAR) were looked at. There were records for medicines that were not required by people on a daily basis. The manager told us additional checks should have been done for these medicines every week. The regional manager checked the file and identified these had not been completed for two weeks. The manager said a senior member of staff responsible for the medicine audits was on annual leave; there were no systems in place to ensure audits were still completed if staff designated to do the audits were absent.

Three of the four care plans we looked at contained errors such as referring to a different person or a previous home the person had lived at. One of the care plan audits instructed staff to remove reference to another home and replace with Highbridge Court. The previous home had been crossed out and 'Highbridge Court' was handwritten alongside indicating the care plan had not been set and reviewed in its entirety since the person moved to Highbridge Court.

A key performance audit conducted by the area manager on 07 January 2016 looked at a range of topics including personal monies and petty cash, training records and staff supervisions. Care plans were also audited. The audit identified that two of the five care plans had not been reviewed within timescales recommended by the organisation. Another audit conducted on 01 January 2016 rated the home good for well-led. The audit identified several areas for improvement including the need to display the previous rating, lack of recording of one training

# Is the service well-led?

course attended and two outstanding actions from the July 2015 audit. The Annual Quality Report for 2015 identified a marked improvement in the home with staff feeling confident in their roles and responsibilities. The Quality Team rated the home as 'good' overall.

We saw a member of the provider's organisation completed a quality audit looking at whether the service was safe in November 2015. The auditor rated the service as 'Good'. This meant although there were more audits taking place, the audits were not always effective at improving the quality of the service. We asked the manager to send us copies of other audits covering effective, caring, responsive and well-led requirements; however the audits the manager sent were from July 2015 and as a result, did not reflect any changes made since the last inspection. The manager said, "Our quality assurance is more stringent, I've improved everything but it's not fantastic yet." We saw the clinical lead had audited care plans separately to the key performance audit in January 2016. In one care plan, they had identified part of the care plan had been written with the wrong emphasis for the person, although they had not explained what this meant.

We saw the staff meetings file contained records of meetings from 29 May 2015 and 25 June 2015. The records had sections which identified the person responsible for any actions identified, the date the actions were to be completed and the outcomes of any actions. Most of these sections were blank. Agendas were available for September 2015, November 2015 and January 2016; however there were no minutes available. As there were no records of what had been discussed or any actions that needed to be carried out, it was not possible to check if any agreed changes had been made. We asked if minutes had been taken and the manager said, "We have a new IT system; one member of staff knows where the minutes are but they're away." This meant information from staff meetings was not readily available to provide staff with any updates they may need to be aware of.

We saw the water hygiene log book where dates when the taps were flushed in empty rooms were recorded. It is recommended that taps are flushed weekly to reduce the risk of Legionella disease. The dates showed this had been done twice in August 2015, once in September 2015, once in October 2015 and then three times in January 2016. The manager said, "There's a sheet missing because I know they were done on Christmas Eve." We saw the 'Safer Food Better Business' file where records should have been kept of kitchen cleaning schedules and fridge/freezer temperatures. No information was available prior to 01 February 2016 and the records had not been fully completed. The manager said they thought this information had been archived. After the inspection, information was provided about food temperature monitoring for the month of January 2016. This meant records were not available to show people were protected from the risk of infection.

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

There was a staffing structure in the home which provided clear lines of accountability and responsibility. People said, "We can talk to the manager but he has a very important job and he needs to do all kinds of different things on the computer" and "He can't be here, there and everywhere." One person told us, "If you had come here in October I would have begged you to get me out of here. There is a new area manager and regional manager. The area manager came here in November and things started to change, but it's been slower than it should have been." Staff said, "I've not had a better manager; he's a friend and you can have a laugh" and "The manager is so approachable; it's nice having a friendly manager, not one you're scared of." Staff also said, "We've got good management now; very knowledgeable, enthusiastic and passionate about the future", "The management is great, really approachable. I could ask him anything and wouldn't feel uncomfortable" and "I feel supported." This meant staff felt they were supported by an approachable manager.

The manager explained the support in place and said, "The new area manager is fantastic, it's like a breath of fresh air. The support is there because I speak with the clinical lead weekly and the nominated individual three times weekly." The manager told us, "I just want it to work; there's so much potential" and "There's an unmet need in Somerset. The plans I've got to get to outstanding are in place." We saw a quality best practice day had been held in 2015, which gave staff information and encouragement to strive to improve services. This meant the provider recognised the need to improve and had shared the learning with all of the staff.

Requires improvement

# Is the service well-led?

A statement on display in the home explained the vision and values of the service to be for people to gain skills and move into the community. One member of staff was able to explain the vision very accurately and told us it meant everything should be person centred.

The home has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>**Regulation 12 (2) (a) (b) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).**<br><br>People who use services and others were not protected against the risks of unsafe care and treatment because risks to the health and safety of service users of receiving care or treatment were not always assessed.<br><br>Regulation 12 (2) (a).<br><br>Highbridge Court did not do all that was reasonably practicable to mitigate any such risks.<br><br>Regulation 12 (2)(b)<br><br>Medicines were not managed safely.<br><br>Regulation 12 (2)(g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>**Regulation 11 (3) (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).**<br><br>Care and treatment of service users must only be provided with the consent of the relevant person, but if Part 4 or 4A of the 1983 Mental Health Act applies to a service user, the registered person must act in accordance with the provisions of that Act.<br><br>The provider did not act in accordance with the Mental Capacity Act (2005). |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Action we have told the provider to take

| | |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>**Regulation 17 (2) (a) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).**<br><br>Systems and processes were not operated effectively to monitor and improve the quality and safety of the service.<br><br>Regulation 17 (2)(a)<br><br>Accurate and complete records were not maintained for each service user.<br><br>Regulation 17 (2) (c) |