Ark Care Services Limited

Highermead Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

We inspected Highermead Care Home on 3 and 4 October 2016. The inspection was unannounced. The service was last inspected in May 2014 when it was found to be meeting the requirements of the regulations.

People who used the service were not always protected from the risks of abuse. There were some instances, where people who were at risk of harm, were not reported to safeguarding authorities, or satisfactory plans were not put in place to minimise the risk of harm to others. Staff were not always trained so they knew what to do if people were at risk of abuse.

There were not always enough staff on duty, and employed to meet people's needs. Staff were seen to work hard, but unsatisfactory numbers of staff meant they struggled to meet people's basic needs.

Although people thought staff were caring, we had concerns about some incidents we witnessed and were told about, which we did not regard as professional and respectful.

There was a lack of activities for people who lived in the home. This meant many people had little to do apart from watch television or sleep. People could not use the garden without staff, and staff had little time to socialise with people.

Care plans did not contain accurate and up to date information, and were not regularly reviewed. Care plans did not provide suitable guidance to help staff where people had complex needs which may have put them and others at risk.

The registered persons had not ensured the service worked effectively to meet the needs of people who lived at the home. Suitable quality assurance systems were not in place to check the service was operating effectively and bring about improvement where this was required.

The Care Quality Commission was not always informed of incidents which according to regulation we need to be informed about as they may have put people at risk.

The building was not maintained to a good standard. For example there was a need to improve furnishings and some fixtures and fittings.

Staff did not always receive a suitable induction, for example working for a reasonable period of time with experienced staff before working on their own. Staff training was not satisfactory to provide people with the skills and knowledge to do their jobs. For example most staff had not received training about the needs of people with dementia.

Medicines were not always given to people as prescribed by their doctor. Medicines were not always stored securely. Staff were not always trained to give medicines.

Arrangements for people to receive suitable help to eat and drink, for example at meal times was not satisfactory. People did not receive the right support when they needed it.

Routines to keep the home clean were not always satisfactory. For example commodes were not always emptied and cleaned in a timely and appropriate way.

People's monies were stored securely, and suitable records were kept of expenditure made on their behalf. Satisfactory checks were carried out before staff members started working at the service. This included references and a check to ensure people did not have any criminal convictions, or there was any other information which meant they should not work with vulnerable people.

Processes to assess people to check they had mental capacity were satisfactory, although most staff had not received training in this area. People had access to GP's and other medical professionals.

Health and safety records were kept appropriately. Checks on fire precaution, electrical and gas appliances were suitably completed.

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

The service was not safe

People were not always protected against the risk of abuse. Suitable procedures were not always followed if there was a safeguarding concern.

Medicines were not always administered correctly, managed or stored securely.

There were not satisfactory numbers of suitably qualified staff on duty to keep people safe and meet their needs.

Is the service effective?

Inadequate

The service was not effective.

The building was not well maintained although satisfactory health and safety checks were completed.

People's capacity to consent to care and treatment was assessed in line with legislation and guidance.

Meal time arrangements were not satisfactory. People did not have suitable access to drinks

Is the service caring?

Requires Improvement

The service was not always caring.

Some of the interactions we witnessed between staff and people did not show respect to people who used the service.

People's privacy was respected, however people were not always given suitable choices about how they lived their lives.

Most visitors told us they felt welcome and could visit at any time.

Is the service responsive?

Inadequate

The service was not responsive.

There were insufficient opportunities for people to participate in satisfactory activities in and outside the service.

People did not always receive care which was suitably personalised or care and support responsive to their changing needs. Care plans were not kept up to date.

People told us if they had any concerns or complaints they would be happy to speak to staff or the manager of the service. People felt any concerns or complaints would be addressed.

Is the service well-led?

Inadequate

The service was not well-led.

The registered persons had not ensured the service operated effectively to meet people's needs.

There were not satisfactory systems in place to monitor the quality of the service, and these were not effective due to the shortfalls we found at this inspection.

Notifications required by the regulations had not been submitted to the Care Quality Commission to inform us of all instances where people may have been put at risk.

Highermead Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We visited Highermead Care Home on 3 and 4 October 2016. The inspection was carried out by one inspector. An Expert by Experience helped the inspector with the inspection. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection was unannounced.

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

During the inspection we spoke with nine people who used the service and observed and spent time with two others who could not communicate verbally. We had contact (either through email or speaking by telephone) with two relatives. We also spoke with the registered manager and eight members of staff. Before the inspection we had written contact with two external health and social care professionals who visited the service regularly. We inspected the premises and observed care practices, for at least two hours each day, during our visit. We looked at five records which related to people's individual care. We also looked at eight staff files and other records in relation to the running of the service.

Inadequate

Is the service safe?

Our findings

People were not safe.

The service had a satisfactory safeguarding adult's policy. Most staff had received training in safeguarding adults, although there was no record this training had been received in two of the staff files inspected. The staff we spoke with demonstrated an understanding of how to safeguard people against abuse. For example, we were told staff would report concerns to managers, and if they did not take suitable action staff would report issues to external organisations such as the Care Quality Commission.

However we were concerned about how two incidents had been managed by the service. There had been incidents involving one person, who lacked mental capacity kissing another person which was not consensual and who also did not have mental capacity. The registered manager said they had reported the incident to the local authority, who said the matter was not a safeguarding issue. A social work assessment was advised. This was completed and the service was advised to keep the two people separate. However records showed there had been at least one further incident, where the police were called. We witnessed an incident where this person was making unwelcome advances to the other person, although a member of staff stepped in and asked the person to leave the room. Of further concern was that this person had been observed kissing a further person who also did not have capacity to consent. Although a record was kept of this incident, the matter had not been reported to the adult safeguarding authority. The service is not ensuring that people are being kept safe from non consenting contact.

There were several recorded incidents where a person had been verbally and physically aggressive towards other people who used the service, and also to staff members. These concerns had not been reported to the local authority under their adult safeguarding procedures and there were no records of the service taking action to prevent this from continuing.

We were told by staff that another member of staff had been dismissed for misconduct. When we spoke to the registered manager about this matter we were told that the person was dismissed for shouting at people in the service. It is important that incidents where people are potentially physically or verbally abused are reported to safeguarding, the police and the Care Quality Commission.

CQC subsequently made a safeguarding alert about these concerns.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

There were not enough staff on duty to meet people's needs. Rotas showed there were three staff on duty in the morning, at least two staff on duty in the afternoon, and three staff on duty until 10pm in the evening. The rota showed on most days there were three staff on duty in the afternoon from 12pm until 5pm. One of these staff was a senior care assistant who had responsibility for co-ordinating the shift and also administering people their medicines. During the night there were two care assistants on waking night duty.

In addition, the registered manager worked at the service during the day, from Monday to Friday, although they had also completed some shifts at weekends. There was a deputy manager in post but she was on long term sick leave. The service always had a cook and a cleaner on duty, during the day.

However we found that the staffing level was not able to meet people's needs at all times. We observed staff were constantly busy, were unable to take any breaks because of attending to people's personal care needs. Staff rarely were seen in lounges, for example spending time with people, apart from when they had to attend to an individual's care needs or give people a drink. Staff told us it could take them until midday to assist people to get up and get dressed. Senior care assistants and the registered manager said they would help care assistants but this was not always possible due to their other responsibilities and duties. Some people had severe dementia which resulted in them needing one to one support with personal care, eating and drinking. Some people had behaviours which could challenge the service, and could be confrontational, aggressive and challenging to others. When incidents occurred with these people staff told us support could be very time consuming for them to provide. For example in order to help calm the person, and others down. In these circumstances there were not enough staff to meet other peoples' needs as staff were fully engaged elsewhere.

The staff we spoke with all said they did not think there was enough staff at the service. We were told staff "Struggle" to ensure people have regular baths. We were also told by staff that they did not have time to provide people with activities, "We try to fit one (an activity) in if we can but it is quite hard to do." Another member of staff said, when asked if there was enough staff, said "I would not say so." The morning shift leader, on the first day of the inspection, was observed as kind and caring but was trying to do lots of different tasks at one time including giving guidance to a new member of staff. We also received comments from relatives and external professionals about staffing levels. An external professional told us, "I think there are staffing issues with not having enough staff. There have been times when I have been kept waiting at the front door for several minutes or waiting inside to speak to a carer about a resident," and "No (there are not enough staff). Also the manager is called in at short notice to provide cover for shifts." A relative said "The home is short of staff and it is chaos at times."

Training records showed staff had received manual handling training in the last year. There was manual handling equipment such as hoists and stand aids. However we witnessed two staff physically lifting, two individual people out of arm chairs. Such a manoeuvre could injure the people concerned, and also the staff performing the manoeuvres. These incidents showed that staff did not have adequate skills in how to move people safely.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

People's medicines were administered by staff. All senior carers had received training to administer medicines. Records showed medicines sometimes needed to be administered overnight. However training records showed night staff had not received medicines administration training.

From August 2015 the Care Quality Commission received three concerns raised by the ambulance service, about medicine errors. For example medicines being given to the wrong person.

Medicines were stored in the medicines room. There was a locked trolley and one locked metal cabinet. Medicines were kept tidily and there was no excessive stock. There was another cupboard which contained medicines which had a door missing. The staff told us they had asked for the cupboard to be repaired on several occasions.

Medicines for the next month, dispensed by the pharmacist on 27 September, had been delivered to the service several days prior to the inspection. These were stored in a box on the floor of the medicines room. The staff told us they had not had time to check the medicines were correct, or ensure they were stored more securely.

There were bottles of liquid medicines, with hand written labels, in one of the medicine cabinets. The bottles contained liquid which the labels stated were liquid 'Senna,' 'Paracetamol,' and 'Lactulose.' The labels did not state these were for specific individual people and the consequence of this was people may have been given medicines for which they were not prescribed or medicine may be shared by different people. The registered manager said the medicines were 'returns' and were not for general use.

Most medicines were signed as administered correctly and we observed staff administering medicines appropriately. However we found ten incidents of dosages of medicines signed by staff, as administered, but still in the monitored dosage system. One person had not had two of their medicines on five occasions over a nine day period as they had been asleep. One of these medicines was for management of their blood pressure. There was no record staff had liaised with medical professionals about the consequences of the person not having this medicine. Medicines requiring refrigeration were stored in a fridge. However refrigerator temperatures were not recorded each day.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

A system was in place to return medicines, for example there was a duplicate book of medicines which were to be / had been returned.

Recruitment checks were in place. Staff had completed an application form. There was either one or two references from someone who had known the person prior to them working at the service. Satisfactory checks had been completed to check that staff who were not citizens from within the European Economic Area had a work permit, and /or had a right to stay within the United Kingdom. There was a Disclosure and Barring Service (DBS) check in the staff files we checked.

Risk assessments were in place for each person. For example to prevent falls, pressure sores, and poor nutrition and hydration. Some people's risk assessments had not been reviewed since August 2016. Incidents and accidents which took place were recorded by staff in people's records.

The service looked after some monies on behalf of people. When staff purchased items, such as toiletries on behalf of a person, a receipt was obtained and the transaction was recorded in a finance record. We checked three people's money and cash kept matched what was recorded in the peoples' records. Staff in the service did not act as appointee for any individuals.

Health and safety standards within the building were satisfactory. The boiler and gas appliances had been tested to ensure they were safe to use. Portable electrical appliances had been tested and were safe. The electrical circuit had been tested and was judged in satisfactory condition. Records showed the passenger lift and manual handling equipment had been serviced. There was a system in place to minimise the risk of Legionnaires' disease. Environmental health and safety risk assessments were in place covering for example manual handling and domestic tasks. There were smoke detectors and fire extinguishers on each floor. Fire alarms and evacuation procedures were checked by staff, the fire authority and external contractors, to ensure they worked. A requirement had been issued by the fire safety officer to improve fire precautions, such as some of the fire doors. The registered manager said suitable work had been completed, although

the fire authority had not revisited the service to check the work completed was satisfactory.

Inadequate

Is the service effective?

Our findings

Staff had not received suitable training to carry out their roles. We received several concerns prior to the inspection about whether staff had received suitable training for example about awareness of the needs of people with dementia. The registered manager had no system to monitor what training the staff team had received without checking individual certificates on each member of staff's file. There was no training policy in the policy file, which would state what induction and training should be delivered, when and at what frequency.

We assessed training required by health and safety law, and also training outlined by 'Skills for Care,' the industry body which provides training guidance to the care industry.

Of the eight staff records we inspected three people had a record of receiving training about dementia awareness. Only one person had a first aid certificate of training received in 2009, although the certificate was valid for three years. Although the cook had received training, none of the other staff had received training about food handling. None of the staff had training about infection control. Gaps in the delivery of training about medicines management, safeguarding, and mental capacity are noted elsewhere in the report. No training was provided to staff regarding how to de-escalate aggressive or challenging situations. It was noted in people's records that staff regularly dealt with incidents where they or others were threatened, or there was physical contact from someone who was distressed or aggressive. Staff had not been trained to competently manage such situations.

We spoke to one staff member who had recently been employed at the service The person had not worked in care before but we were told they had only completed one shift, as part of their induction, where they had been rostered in addition to existing staff. They then only had two further shifts on the rota working alongside more experienced staff before they worked completely on their own assisting people with significant personal care needs. This new member of staff had not received adequate training to be competent to meet the needs of people with significant care needs.

The lack of provision of induction and training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Staff told us they felt supported in their roles by colleagues and senior staff. There were very few limited records of recent individual formal supervision with senior staff. Staff said they could approach seniors or the manager if they had a problem or a concern. For example one member of staff said when we asked them if they had supervision: "No, but (the registered manager) will give you the time as necessary." Six of the staff had received training about fire prevention in the last year. In respect of other training five staff had a record of manual handling training (although no copies of certificates) on their files. Staff comments about the training received included "If training comes up they put us on it," and "There is some training lined up." There was a record that six people had received an induction of which records looked comprehensive, though the service did not have an induction policy. However the registered manager said she was aware of the need for staff, who were new to the care industry, to undertake the Care Certificate. The Care Certificate

is an identified set of national standards that health and social care workers should follow when starting work in care. The Care Certificate ensures all care staff have the same introductory skills, knowledge and behaviours to provide necessary care and support. There were copies of the 'Care Certificate' on the files of several staff. The registered manager worked at the service, during the day, Monday to Friday, and also did some shifts at weekends.

We looked at the maintenance of the building. We found that the outside of the building and its entrance were untidy. The exterior of the building needed painting. There was an outside patio, visible to people but not used, which was unswept and had debris in bin liners which had been left from a clear up by students in the summer term.

Many of the interior areas also needed decorating and refurbishment. Paintwork was in places scored and chipped. Carpets in hallways and corridors were in places heavily stained, and there were several areas where carpets were frayed and presented a trip hazard. The floor covering in the downstairs hallway also presented a trip hazard. The floor covering in one of the ensuite bathrooms was badly stained. A small table, used to put hot drinks on, in the television room was wobbly. There was an ensuite shower in at least one bedroom. A relative of the person who used the room said that it was not suitable for people who were frail or had a disability and therefore was not used. An external professional said "Highermead does appear 'tired.' Internally it would benefit from a fresh coat of paint and maybe new soft furnishings." Staff told us there was no maintenance person to do small maintenance jobs in the building. However the quiet lounges, and the television room were light and cheerful, and there were flowers in the television room.

At our request the registered provider sent us a schedule of planned maintenance for 2016/2017. This included painting the inside and outside of the home, installing a wet room, and replacing carpets in the lounge and upstairs corridor. This however did not include replacing all the floor coverings we judged needed replacing. For example the downstairs carpet in the bedrooms' corridor was badly stained but there was no plan to replace it.

Some people said the view from the TV room was lovely and it was a sunny day. However there was nowhere people could go and sit outside, or walk around independently. For example there was no secure outside area where people could go for exercise or have an opportunity to have some fresh air. We did not see staff provide people with the opportunity to have any exercise.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

We did not see any of the people being given or having access to water or soft drinks apart from at lunch time. There were no jugs of water or water dispensers in any of the three sitting rooms. There were not enough side tables for each person to have one next to their chair to put drinks on. One person had a water jug in their bedroom, but this was approximately two metres from them on a chest of drawers. The person was not able to walk well enough to get the jug.

People told us they could have their meals in the dining room, the lounge or in their bedrooms. On both days of the inspection people were led to the dining room to have their meal. People then had to wait for the food to be served. On the second day of inspection there was a wait of at least twenty minutes before the first person was served. Some of the people who first came to the dining room were not served first, so had to wait longer. We saw some people became anxious about where their food was. Three of the people in the dining room needed help with eating, but only one member of staff was in the room to assist people. The member of staff left one person with food visibly sitting in their mouth unswallowed whilst the member of

staff went to a different table to assist another person. Another person was unable to lift their drink to their mouth due to very shaky hands. The member of staff said they would help in a minute but they did not come back to the person to give further assistance. We therefore concluded that the organisation of the mealtimes did not meet people's individual needs.

One person had their meal in the lounge, but would leave their chair and walk around the home. They would leave their food to get cold. We sat with the person and noticed they were dipping their finger into their dessert and trying to eat it. The rest of the food was untouched. We went to see the registered manager about this and suggested the person might want some assistance. The manager said the person did not like staff helping them, but came with us, and when help was provided they readily ate their dessert. We suggested the person was provided with a serviette to clean their hands, but were told "We don't give (the person) serviettes, (they) eat them." This meant the person was not provided with the support or encouragement needed to assist them to eat effectively or were provided with appropriate means to clean themselves after their mealtime.

A tea and coffee trolley went around the home mid-morning and mid-afternoon. On one occasion we noted people were not provided with a choice of hot drinks. The member of staff said they knew what everyone wanted. On another round people were given a choice. On both rounds biscuits were given out by hand, not put on a plate and people were not given a choice. There was only one type of biscuit, and cakes or other snacks were not offered. This meant that people were not always given a choices in the drinks provided to them.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The sluice machine (for cleaning commodes) upstairs in the building was broken. The registered manager said this had not worked for many years since she had worked at the service. We were told commodes were emptied in the toilet and washed in a bath. We were told the bath was no longer used by people who used the service. Open sluicing is a risk to people and staff when carried out without appropriate protective equipment.

People's bedrooms were not always suitably cleaned and tidied. Two people shared a bedroom. On the second day of the inspection we inspected this bedroom at 12:30pm. Both beds were unmade and the commodes had been used, were soiled and were uncovered. We were aware the two people had been downstairs in the lounge since mid-morning. We checked the bedroom again at 1:30pm and also at 4:00pm and the commodes had still not been emptied and the beds still not made.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

People were happy with their meals and said their meals were very nice. There was a choice of meal at lunchtime. We saw a member of staff meet each person, in the morning, and ask them what they would like for their lunch. At lunch time we observed one person who did not want to eat any of their meal and was subsequently provided with a plate of sandwiches which they subsequently ate. People told us they had a choice of sandwiches or a hot snack (such as soup) in the evening. The main meal was displayed on a blackboard in the dining room.

The service was generally clean although some parts of the building looked unkempt for example the entrance to the home. On the first day of the inspection, after morning tea and coffee the mugs were not

tidied away until sometime after lunch which gave the sitting rooms a messy feel. There were no offensive odours in the general area of the home.

The service had some appropriate aids and adaptations for people with physical disabilities such as a bath hoist and a passenger lift. The registered manager informed us one of the bathrooms would be converted into a wet room by the end of 2016. The service had a call bell system. We asked people if call bells were answered. People told us staff would answer call bells promptly in most instances. For example we were told "Carers would be up in two or three minutes," although we were told by another person, " "Depends on how many other people are calling them(the staff)."

People's capacity to consent to care and treatment was assessed in line with legislation and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People had a mental capacity assessment within their care files. This detailed in what areas individuals had (or lacked) capacity. However, the form did not specify what actions had been taken, if a person lacked capacity. However where appropriate Deprivation of Liberty Safeguard (DoLs) applications had been submitted to the local authority, when the registered manager had judged an external mental capacity assessment, and possible DoLs application needed to be completed. The staff we spoke with had a basic awareness about mental capacity although three of the eight staff records we assessed had no evidence that these staff had received training about mental capacity and deprivation of liberty safeguards. One external professional also commented they thought staff did not have adequate training in this area.

People told us they did not feel restricted. However people were reliant on friends and relatives to take them out, as they were unable to go out independently alone, and staff did not provide activities to take people out.

People told us they could see a GP if requested. We were also told that other medical practitioners such as a chiropodist, dentist or an optician visited the service. Records about medical consultations with GP's were satisfactory, and there were also records of opticians and dentists appointments.

Requires Improvement

Is the service caring?

Our findings

People provided some positive comments about staff who worked with them. Comments received included "It is nice here, the staff are kind," "(We are) very well looked after here. We are treated very well." Relatives told us "Staff are very patient." Professionals stated "I have always found staff to be helpful (and) sensitive to the individual resident's needs."

The majority of the time we observed staff working in a professional and caring manner. Staff were observed constantly working very hard to meet the needs of people without any noticeable breaks. Staff were observed to be calm, and did not rush people. The people we met were all well dressed and looked well cared for. People's bedroom doors were always shut when care was being provided.

Many of the people were able to have conversations, or communicate, on some level. They seemed happy to do so when staff or inspectors were with them. We did not see any incidents when staff just sat and chatted with them.

We received several reports, from different sources, that some staff, on some occasions, shouted at people. The comments received included "I have heard staff shout if it has been a long shift and people are tired. Staff need to remember it is the dementia not the person." Another person said, "Some of the staff are wonderful but they are under a lot of pressure. Certain staff can be short tempered with some residents." However one external professional said "I have never seen evidence during my visits that a carer has acted or spoken to a resident with dementia inappropriately."

During the inspection we did not witness any staff shouting at people. We did however witness some inappropriate interactions between staff and people using the service. For example one person told us that someone had stolen some money from them. When we reported this to the registered manager we were told the person, in front of them, did not have any money. The person then spoke to another member of staff about the money, and was told in front of other people, they did not have any money. When we raised the matter after the inspection the registered manager told us the money had been found.

On another occasion a person said to a member of staff another person should use a walking stick. The person was promptly put down for their idea by a member of staff. We did witness some staff also speaking with people in a tone of voice that may be used to address a small child.

We also observed one person walking around the home looking tearful. We were concerned no member of staff stopped to ask the person if they were okay. When we spoke to the person they were clearly distressed and confused by being separated from their family.

We also noted someone pulling up their trouser leg to reveal a full catheter bag. A member of staff saw what the person was doing and told them to pull down their trouser leg. The member of staff did not stop to look at the full bag or do anything about it.

We observed one person, asleep in their chair, with an uncovered commode full of urine and faeces within two metres of them. When we first observed the person at 12:30pm they had a luke warm cup of tea in front of them, and two biscuits. We revisited the person, at 1:30pm the commode had not been emptied, yet there was an empty dinner plate in front of them. The now cold cup of tea and biscuits were still in front of the person. The person was asleep. We were concerned a staff member had obviously brought the person's meal to them, and had ignored the need to arrange for the commode to be emptied, and the cup of tea of tea to be removed. It was not until between 1:30pm and when we revisited the room at 4pm when these matters were attended to. There was no record either in the person's bedroom, or their records, of how often staff checked the person, in their room, to see if they needed any help.

We have noted elsewhere in the report concerns about staffing levels and also staff training and judge these to be contributing factors to some of the behaviour we witnessed. However we were concerned to witness staff dismissing people's views, and treating people in a manner which could be deemed as disrespectful, ridiculing and belittling.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Care plans we inspected contained information to assist staff to understand people's needs, likes and dislikes. However information was variable and not always updated. We were told by some people and their relatives, there was involvement in the drawing up of care plans. Some people told us staff would ask them how they wanted particular help with a task such as washing and dressing.

People said their privacy was respected, for example, we were told staff always knocked on their doors before entering. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments, to help people feel at home. The people we were able to speak with all said they found their bedrooms warm and comfortable.

People did not have a choice of a male or a female staff to provide their personal care. For example on one shift, on both days of the inspection, two of the three staff on duty were male despite the majority of the people using the service being female.

Some visitors told us they were made welcome and could visit at any time. However we received reports visitors did not always feel welcome. People could go to their bedrooms, and also to one of the lounges if they wanted to meet with visitors.

We found that the service did not take appropriate validation checks when workers came to the service. For example a maintenance person came to service the boiler. The person was let in the building without any check on the person's identification. The member of staff did not appear to know the visitor.

Inadequate

Is the service responsive?

Our findings

One of the two main lounges was deemed a 'quiet' lounge, but also contained a music system which was not used on either days of the inspection. The other lounge had a television on. The channel on the television was not changed. People were not asked if they wanted something else on, or the television turned off during the periods we spent in this room. We spent two hours in this room on each day of the inspection. For the majority of the time, the people in both lounges were asleep. Staff attended the lounges irregularly for example to perform a personal care task such as to take people to the toilet or bring around teas and coffees.

We found no activities were provided at the service. We saw no evidence people were supported to maintain hobbies or interests. Staff told us they did not have time to provide any activities and no external entertainers visited. We were told there were no trips out. Two people attended a memory café. These people were assisted by an external care agency. This support was paid for by a third party. People were unable to go out into the garden as the outside doors were locked. The garden was not a secure area so people would have been able to leave the grounds, which would have put them at risk. We saw very little chatting between staff and people as staff were too busy attending to personal care tasks. The registered manager said the service had tried to recruit an activities organiser but had been unable to do so.

One person had received an assessment from NHS Occupational Therapy (OT) to assist them to have more activity. The initial assessment was completed in March 2016, and reviewed in September 2016. From our inspection of care records, there was no evidence any recommendations (such as having music playing in the person's room, or arm chair exercises) had been trialled with the person, or any ideas had been added to the person's care plan. The OT plan had not been implemented in any way.

There were no religious ministers visiting people at the service. The registered manager said ministers used to visit, but they now were unable to do so. The local library did not visit.

Some of the relatives and professionals expressed concern about the lack of activities at the service. We were told "My relative is an intelligent person but there is no stimulation there," and "I feel with more staff more activities could be planned."

We concluded that arrangements for activities at the service were not acceptable as people did not have the opportunity for any stimulation or exercise, or to be able to go outside of the home.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Each person had a care plan in their individual file. Files were stored in the office. Care plans contained assessments of people's needs and any risks. Care plans covered areas such as the person's physical health, personal care needs, and moving and handling needs. The registered manager was in the process of rewriting care plans. Subsequently some people had an 'old' style care plan until the registered manager

had time to write its replacement, and other people had a 'new' style care plan. None of the 'new' style care plans had been reviewed since August 2016.

In respect of the 'old' style care plans, daily records were being maintained. However other records were not being updated or reviewed; for example risk, nutrition and continence assessments. Care plans for two people were last reviewed in April 2016 and May 2016 respectively.

In respect of the 'new' style care plans, most of these contained detailed information which would help a new member of staff provide care for a person they did not know well. However some of the information was less informative and helpful. Some of the assessment sections of the care plans were in a question and answer format, where the writer had just recorded the answers people had provided. Some of the answers included "I don't know," "Go away," and "I don't have any hobbies. You are keeping on at me…go away," which were not helpful to a reader who was trying to find out a person's needs.

Some people who used the service had behaviours which at times could be aggressive or challenging. For example one person would exhibit behaviours such as pinching, pulling hair and scratching staff, particularly when staff assisted the person with personal care. Another person could be physically and verbally aggressive to others. There was no specific guidance in either person's care plan about what staff should do to help minimise the behaviours, or how to deal with them when they occurred. Some people were prescribed sedative medicines to help calm their behaviour. This medicine was given as and when it was required. We did not see any specific guidance about when this should be given, or specifically why it was administered when it was given.

Some people had toileting records, and bathing charts. These were irregularly completed. For example one person was recorded as not having a bath from mid-June to the date of the inspection. We were not able to identify if the record was accurate. Some people had charts which showed what they ate and drank each day. Some people we met did not eat and drink regularly, and because they did not communicate verbally it was necessary to keep detailed records to prevent malnutrition and dehydration. However the records were not very detailed, and did not provide satisfactory information to alert staff if there was a problem. Some people had weight charts. Some of these were regularly completed although some were not. For example one weight chart was last completed in May 2016. Another person's weight chart was last completed in mid-September and stated the person should be weighed again the next day due to a significant difference from when the person was last weighed. This was not done.

A 'Life Story Book' form had been put in many files. The intention of the form was to provide for example the history of the person, their likes and dislikes, hobbies, and their family and work history. This was to enable staff to get to know the person, particularly if they were unable to verbally communicate. In all but a few cases these had not been completed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

We observed care practice throughout the two days of the inspection. The daily routine involved staff assisting people to get up during the morning, people having lunch, and the majority of people spending their time sitting in two of the three lounges. Coffee and tea were brought around mid-morning and mid-afternoon. Some people had visitors. A minority of people spent the majority of their time in their bedrooms.

Before people moved into Highermead Care Home, the service assessed whether it could meet people's needs. Assessment records were stored on people's files and assisted staff to write people's care plans.

People we spoke with said if they had any concerns or complaints they would feel confident discussing these with staff members or management, or they would ask their relative to resolve the problem. The Care Quality Commission received some concerns from ex-employees, and external professionals since 2015. Some of the themes raised in these were looked at as part of this inspection. We were not able to identify if any complaints had been made to the service.

Inadequate

Is the service well-led?

Our findings

There were a significant number of concerns we found at this inspection which caused harm and risk to the people that used the service. People were not being adequately cared for. The registered manager said staff shortages had caused lots of difficulties in the last few months. The manager said they had informed the owner of many of the concerns about the operation of the service such as the difficulty in recruiting staff, and the high needs of people accommodated.

When we discussed what systems were in place about quality assurance the registered manager was not clear what we meant. After discussion the registered manager said they would spend a lot of time speaking with staff, families and professionals. The manager said they would "go around rooms," to check they were clean and well maintained. She said there were audits of medicines, health and safety and infection control. She said a survey of relatives' views had been completed, by the owner, but the manager had not been provided with a copy of the results.

We were shown only one undated infection control audit, and health and safety audits which had been completed only three times since December 2013. We saw only one report when the registered manager had visited the home at night, in January 2016. Staff told us there had been two staff meetings in the last two years. We did not see any other evidence of other activity referred to in the service's quality assurance policy.

Due to the significant number of concerns about the service, and breaches in regulations outlined in this report we found that the service had not been adequately monitored.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The registered provider was registered with the CQC in 2010. The provider is required by law to submit notifications to CQC of significant events such as injury or any safeguarding concerns. CQC has received some notifications of deaths and serious injuries. However Deprivation of Liberty Safeguard notifications, not all safeguarding concerns, incidents reported to the police and serious incidents such as medicine errors were not reported to us. We found the service had not submitted statutory notifications as required.

This was a breach of Regulation 18 if the Care Quality Commission (Registration) regulations 2009.

The service had a quality assurance policy. This stated there would be monthly visits from personnel from the organisation's headquarters. Managers would perform monthly checks on the service. There would be satisfaction surveys and consultation meetings for example with people and their families. There would be a 'continuous improvement plan'. The policy was signed off by the registered provider in August 2016. A summary of the results of the annual survey were faxed to the service from the head office. This showed respondents were happy with the service. We were also provided with a maintenance plan of work completed / to be completed between October 2015 to February 2017. This included redecoration, repairs to windows, decoration and replacement of some carpets.

Staff said overall there was a reasonable culture at the service. For example, "Generally it is a lovely place to work." It was clear the manager and the staff team had worked hard together to continue despite staff shortages and the significant needs of some of the people who lived at the service. A relative said "Staff are very patient."

The management structure of the service consisted of a registered manager who generally worked at the service during the day, Monday to Friday, but also completed some shifts including at the weekend. The service used agency staffing at times. The service had a deputy manager, but this person was on long term sick leave. The owner of the service lived in London, and had another home in Lancashire. We were told the owner visited the service regularly. The registered manager said if staff had any problems they were also able to telephone her at home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications required by law were not always provided to the Care Quality Commission

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Arrangements to support people with their meals were not satisfactory. There were not appropriate arrangements for people to access fluids. Arrangements for people to have suitable activities, exercise, education and recreation were not satisfactory Care planning, and arrangements to review them, were not satisfactory. Care plans did not provide staff with necessary guidance to provide people's care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Care provided to people, by staff, was not always carried out with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 12 HSCA RA Regulations 2014 Safe

personal care	care and treatment Systems and training to manage people's medicines were not satisfactory. Arrangements for cleaning the home, and for cleaning commodes were not satisfactory.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Concerns which put people at the risk of abuse were not referred to the local authority under their safeguarding procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The décor, upkeep, maintenance arrangements were not satisfactory. People were also not able to access a safe area outside of the service to spend their time

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not effective. Arrangements to effectively oversee the service were not satisfactory

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient to meet people's needs. Staff induction and training were not satisfactory to meet the needs of people