Sterling Care (Uk) Ltd

Highfield Residential Care Home

Inspection report

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30 January 2019

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: Highfield Residential Care Home is a residential home that is registered to provide accommodation and personal care to a maximum of 20 people over the age of 65. At the time of inspection 18 people aged 65 and over were living in the home. On the third day of inspection there were 16 people living in the home.

People's experience of using this service:
•□People did not receive a service that provided them with safe, effective, compassionate and high quality care.
•□Individual risks to people were not managed and mitigated including risks posed to people by the environment.
•□There were not sufficient staff to meet people's needs or keep them safe.
•□People's human rights were not always upheld as the principles of the Mental Capacity Act (2005) were not adhered to.
•□People were not always supported to eat and drink enough to maintain a balanced diet.
•□Peoples needs were not holistically assessed to ensure that staff were able to provide the care that people needed.
•□People were not always treated with privacy and respect.
•□The service was not well led and the provider did not have systems and processes in place to monitor the quality of the care that people received. There had been a consistent failure to improve and ensure care was delivered within the legal regulations of the Health and Social Care Act.

Rating at last inspection: At the previous two inspections in May 2018 and August 2017 the service was rated inadequate and placed into special measures. We identified breaches of regulations 9, 10, 11, 12, 17, 18 and 20A. At this inspection, we found that the necessary improvements had not been made. The service had six repeated breaches and a new breach of regulation 19.

Why we inspected:
This was a planned inspection based on the rating at the last inspection.
Enforcement: Following the inspection in August 2017, we imposed conditions on the provider's registration because they failed to make the required improvements in relation to three of the regulations. These included regulations for safe care and treatment, meeting nutritional and hydration needs and good governance. The condition required the provider to submit monthly reports to the CQC in relation to risks to the environment, risks to individuals and review accidents and incidents. The provider sent us monthly reports, however these reports did not include detail of actions taken to address and mitigate risks both to individuals and in the environment.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Highfield Residential Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The service was inspected on 15, 18 and 30 January 2019.

Inspection team:
The inspection was carried out by four inspectors, a medicines inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: Highfield Residential Care is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Highfield accommodates up to 20 people, some of whom may be living with dementia, in one adapted building. On the first two days of our inspection there were 18 people living in the home and on the third day of inspection there were 16 people.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. In this case the registered manager was also the provider. For the purposes of this report they have been referred to as the provider.

Notice of inspection:
This inspection was unannounced.

What we did:
Before the inspection we reviewed the information we held about the home. This included any information we had received from the public or third parties such as the local authority. We also reviewed notifications the provider had sent us since our last inspection. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters.

We also reviewed information the provider had sent us. After our inspection published in November 2017 conditions were place on the registration and the provider was required to send us monthly reports covering the areas of risk to people using the service and the actions that they had taken to mitigate those risks.

During the inspection we spoke to
•□Five people living in the service and two relatives.
•□The provider
•□The administrator
•□The activities co-ordinator, two senior carers, three carers and the housekeeper.
•□Two professionals who worked with the service.

We looked at
•□Four peoples care records in depth, and specific sections within a further three care plans.
•□Personal care records and daily records including food and fluid charts for five people.
•□A member of the CQC medicines team looked at how the service managed people's medicines and how information in 15 people's medication records and care notes supported the safe handling of their medicines.
•□We checked records in relation to the management of the service such as health and safety audits, audits of care records, records of meetings
•□Four staff files including recruitment and training records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

- We found at the last inspection in May 2018 risks to people were not managed safely. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- At this inspection we continued to have concerns about the management of risks.
- Individual risks to people were not managed and mitigated sufficiently. Some people in the home were at risk of developing pressure ulcers. One person had been identified on leaving hospital that they should be repositioned regularly to minimise the risk of developing pressure ulcers. Staff told us that this person was repositioned at night but not during the day as was required. Records we reviewed confirmed this person was turned at night, but not on a regular basis. Our own checks during our inspection confirmed that the person was not repositioned during the day.
- We found that while people's weight was monitored there was no consistent assessment or management of people's risk of malnutrition.
- Peoples whose behaviours may challenge others were not consistently managed. One person was described as both "No behavioural issues", and "Occasional verbal aggression" in their care plan, but this also stated they could be "aggressive" and have "challenging behaviour". This person had a behaviour care plan with an objective which stated,"To act in (their) best interest and to support to stay calm." There was no specific guidance on how to support this person with their behaviours, or what might lead them to become anxious or distressed. This person also shared a room and there was no risk assessment on how their behaviour might impact on the other person.
- We found that risks to people's safety around the home continued not to be adequately managed. For example, we observed keys left in the medicine cabinet in the corridor unsupervised.
- The kitchen door was left unlocked when staff were not always present. This could place people living with dementia at risk of harm if they do not understand the risks of the kitchen environment.
- Risks within the environment continued not to be mitigated. Records showed hot water cylinders were still not storing water at the required 60 degrees centigrade. It is important for hot water to be stored at this temperature to minimise the risk of legionella bacteria developing in the hot water system.
- Records relating to fire safety showed that some automatic door closures previously identified as faulty, had not been fixed. On our third day of inspection we found nine doors either did not close in response to the alarm, or if they did close they did not fit the door frame properly. One of the doors that did not close was the kitchen door. We also noticed a fire exit sign was not secured, but was sitting on a table and could be moved. This meant that people were not fully protected in the event of a fire
- On the second day of inspection, one person had a call bell that was not plugged in properly at the wall and so did not work. Another person rang their call bell for them. A member of staff told us they could not hear call bells ring in all areas of the service. They also told us that the control panel did not always indicate

when a bell was called, we also observed this to be the case. Another staff member told us the call bell issue had been reported to the provider but no action had been taken.
•□On our third day of inspection we found that despite raising this with the provider on days one and two, 16 call bells were not working properly.
•□There were risks to people because of the design of the building, however an assessment of these risks had not been completed. For example in some areas the floors were sloping and equipment stored in corridors that could present a trip hazard for people with limited mobility.
•□We found radiators and a towel rail which were uncovered and were very hot to touch in peoples ensuite toilets. The hot surfaces presented a burn risk, particularly as some people had mobility issues and were at risk of falling against them and not being able to move away. We asked the provider to make sure that these were made safe. Following the inspection the provider told us that they had arranged for covers to be fitted.
•□The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
•□We found at our last inspection in May 2018 that there were not sufficient numbers of staff to meet people's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
•□At this inspection we found there were still not sufficient numbers of staff to meet people's needs.
•□When we spoke to people. One person told us "No! Three [staff] on in the morning and three in the afternoon, it's not enough. At night I can wait for two hours for help because they're [staff] so busy." Another person said "Oh the home is constantly short-staffed. The staff are so busy all the time."
•□Staff we spoke with also told us that there were not enough staff to meet people's needs, particularly because there were 10 people that needed two people to support them. They told us this meant that people had to wait for personal care and it was difficult to find time to encourage people to drink. Staff also said that they did not have time to support people to move or walk more during the day to help prevent pressure ulcers.
•□On the first day of inspection we saw there were times when staff were not always present in the communal areas of the home. There was also a person cared for in bed upstairs and for long periods we observed that there were no staff present upstairs.
•□The failure to ensure that there were sufficient numbers of staff to support people's needs was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□Staffing recruitment records were not completed as is required. During our checks, we identified that the necessary references, full employment histories and reasons for leaving previous employment were not obtained for all staff. Employers are required to obtain satisfactory evidence of an applicants conduct in previous employment in health and social care and why this employment ended. This is so they can assure themselves that the person is suitable to work in a care home.
•□Failure to ensure that suitable people are employed in the service of this type is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Using medicines safely
•□At our last inspection we found that peoples medicines were not always administered or managed in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
•□At this inspection, we found some improvements had been made in the administration of medicines, but

further improvements still needed to be made

•□Supporting information was available for staff to refer to when handling and giving people their medicines. There were regular internal audits to check people's medicines. When issues were identified they were logged and investigated by the management.

•□When prescribers made changes to doses of medicines, records were not always accurately updated to ensure the medicines were given safely at the correct doses.

•□People's known allergies and medicine sensitivities were noted but for two people we noted inconsistencies in the information available.

•□When people were prescribed medicines on a when-required basis, including pain-relief and sedative medicines, there was not always written information available to show staff how and when to give them to people to ensure they were given consistently and appropriately. However, for one person there was written information in place but staff were giving the person this medicine regularly at the prescribed limits and not only on an occasional basis. We noted that records mostly did not justify why the medicine had been used so it may not have been given appropriately. A senior carer we spoke with said they were unaware that this medicine was prescribed on this basis.

•□For people prescribed external medicines such as creams and ointments there was information showing where on the body the medicines should be applied. However, we noted that containers of external medicines were not always handled in a way that would indicate, once opened, when they would expire and so ensure they were still safe for use.

•□Medicines requiring refrigeration were stored within the correct temperature range. However, we noted that these medicines were not being stored securely. In addition, we also noted that during a medicine round, medicines were not secured whilst unattended by staff with the potential that people living at the service could access them and cause themselves accidental harm.

•□We saw from the records that the provider had carried out observations to assess the competence of staff to administer people's oral medicines. However, one senior member of staff had not recently been assessed as competent.

•□Staff authorised to handle and give people their medicines had been assessed separately by community nurses as competent to give people insulin by injection.

Learning lessons when things go wrong

•□The provider recorded accidents such as times when people had fallen. However not all safety incidents or near misses were recorded. This meant lessons were not always learned and improvements made when things went wrong. For example a health and safety audit noted that toiletries had been found on someone's bedside cabinet but needed to be put away in a cupboard to prevent the risk of the person coming to harm. The same issue was noted on an audit in the same room ten weeks later.

•□By not recording all safety incidents there was no opportunity to review lessons learned and prevent repeated occurences of the same incidents.

•□The provider carried out a monthly audit of those incidents and accidents that were recorded. These were primarily for falls. We saw action was recorded such as "Remind [name] to use their frame", or "Spoken to GP and family."

Preventing and controlling infection

•□Staff did not always follow safe infection prevention and control practices. For example, we observed staff not wearing gloves and touching peoples food with uncovered hands. On the third day of our inspection we found commodes to be dirty. Most other areas of the home were clean.

•□The home had a food hygiene standards agency rating of five, the highest rating. However, we found staff did not always label foods before storring to show when they were prepared.

Systems and processes to safeguard people from the risk of abuse

- Staff we spoke to could describe the different types of abuse people were at risk from.
- Staff knew how to report concerns within the organisation. However some staff did not know who they could report to outside of the care home.
- Staff told us that they had received training in this area and the records we looked at confirmed this.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Ensuring consent to care and treatment in line with law 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 they lack mental capacity to make particular decisions, any 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- At our inspection in August 2017 we found the provider was not working within the principles of the MCA and was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- At our inspection in May 2018 we found that some improvements had been made but further improvements were still needed.
- The service did not always act in accordance with the principles of the MCA. Some people lacked the capacity to make decisions for themselves and required staff to make decisions in their best interests. We did not find any mental capacity assessments in people's records. The provider told us they had taken these out of the files to review them because they had noted some problems. Mental Capacity Assessments had been carried out for some people. However there were not assessments specific to each care task.
- Care plans stated that staff should act in a person's best interests but there was no recording of best interest decisions where people were assessed as not having capacity. This meant that there was no guidance for staff on what was in the best interests for an individual.
- Throughout the care plans, information about people's mental capacity was unclear. Some people identified as having problems with cognition had notes elsewhere in their care plans stating "Mental Capacity, no problems." When we spoke to staff they gave conflicting information about whether or not people had capacity.
- The provider had made applications for deprivation of liberty safeguards authorisation. However staff were not clear who these applied to. The provider had also made applications for people that they deemed to have capacity. DoLs applications are intended for those people that are not able to consent to their care.

This showed a lack of understanding of the legal requirements of the MCA and DoLs.
•□People had signed to consent to care plans and to consent to the use of CCTV in the communal areas of the buildings. Where people did not have capacity, relatives had signed these consent forms. However there was no evidence to document their legal authorisation to do so.
•□This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□Staff we spoke with told us they obtained consent before providing care to people. We saw staff asking people for consent to care, for example we saw staff asking a person if they would like support before supporting them to walk with their frame into the living room to sit down.
•□We also saw instances where staff did not seek consent. For example at lunch time a member of staff loaded food onto a spoon and took it to the person's mouth without asking for consent. The person shook their head when this happened.

Supporting people to eat and drink enough to maintain a balanced diet
•□Some people had been identified as at risk of malnutrition in their care plan. However the provider had not systematically assessed people's risk of malnutrition. The provider was monitoring people's weights but did not take action where people lost weight. For example, we found one person's care plan identified 'recent weight loss', but there was no plan to introduce snacks or fortified foods for this person.
•□The provider did not use a recognised tool to assess whether people were at risk of malnutrition. For example the Malnutrition Universal Screening Tool (MUST) can be used to assess this risk. People had not been placed on a fortified diet where MUST scores would indicate that they were at risk of malnutrion.
•□The cook had a list of peoples food and nutrition needs and prepared food according to these identified needs and preferences. Several people in the home were diabetic and the cook knew their likes and dislikes and prepared separate diabetic meals. However, one person had been identified in their assessment from the local authority that they required a low fibre diet. The cook was not aware of this and it was not noted in their care plan. We asked the provider about this and they were not aware either. They said that they would address this.
•□People did not have free access to drinks at all times in communal areas. On the second day of inspection we witnessed one person ask for a drink three times over a period of 45 minutes before they were given a drink. This person said, "I have been told I need to drink more."
•□On the first day of inspection the morning tea trolley was late because the member of staff who normally did the drinks round did not come into work until later. The provider was aware that this person would be late getting in to work that day, but no provision had been made to offer drinks before they got there. This meant that the tea trolley went round close to lunch time. At lunch time we observed that several people drank their drinks very quickly indicating that they were thirsty.
•□We looked at the records of food and fluids for people. These recorded what people had to eat and drink every day. We checked the records of food that people had eaten against our observations and saw that the recording was not always consistent with our observation. For example one person did not eat much of their main meal, however in the record it said they 'ate well.' Another person was recorded as having 200ml (one cup) of juice, but was observed to have two cups of juice.
•□Where people were at risk of not eating or drinking enough to stay healthy, targets of how much people needed to have had not been set.
•□On the second day of inspection we witnessed the fluid totals being completed in the record at the point that drinks were ordered rather than after people had finished their drinks. This meant that we could not be confident that these were a true record of what people had consumed.
•□People told us that the food was good. One person told us "A very good choice. Providing you let them

know in time that you don't fancy what's on, they'll make you an omelette or something." However another person told us "The portions aren't big enough for me."
•□People were supported to eat their meals and staff stayed with people to monitor them while they were eating.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•□Records we reviewed showed for recent admissions, peoples needs had not been fully assessed. Care plans and risk assessments were not fully completed. One person who had moved in the week before our inspection had no care plans or risk assessments completed. If people's needs are not assessed prior to them coming to the home then staff do not know if they will be able to support them and meet their needs.
•□Staff told us that they knew people well as they cared for them regularly. However, the home used temporary staff from an employment agency to cover shortages. These temporary staff did not attend the home consistantly so would not get to know people well and would rely on information contained within peoples care plans to support them. If peoples care plans are not complete then these staff would not be able provide holistic and consistent care for people.
•□There was contradictory information recorded about the equipment people needed for support with mobility. This meant that staff did not have the guidance they needed to support people to move safely.

Staff support: induction, training, skills and experience
•□Not all staff working at the home had received the training identified by the provider as being required to meet peoples needs. We looked at staff training records and we could see that staff had received training in areas such as safeguarding, moving and handling people, infection prevention and control and mental capacity. However some staff had not received training in person centred care, nutrition and hydration, dementia awareness, pressure ulcer and wound care.
•□Most of the training was delivered by the provider. The provider felt that this enabled them to be flexible about when training was delivered and meant that they could adapt the training specifically to the issues in the care home. However staff feedback was mixed. Several staff felt that the training did not give them the skills and knowledge that they needed to support people and there were gaps in knowledge in certain areas including mental capacity.
•□We asked the provider for records of their competence in the relevant subject areas to deliver training. They had attended some training by external organisations, but could not assure us that they had attended recent training in areas such as safeguarding and mental capacity. They had completed a dementia care coach qualification five years ago but nothing more recently which meant that they were not keeping up to date with best practice in delivering care.
•□Staff training records we reviewed only detailed observations of staff competency in the administration of medicines. Observations of practice and competence were not undertaken in any other area.
•□Staff told us that they had regular supervisions. Several staff said that they did not find these very helpful. One member of staff said, "They are very basic [provider] doesn't tend to ask if you want extra training, all very generic." A second member of staff told us supervisions were, "Not very helpful."

Adapting service, design, decoration to meet people's needs
•□There was some adaptation of premises for people living with dementia. The menu on the noticeboard on the first day of inspection showed a picture of the lunch that day. There were large symbols on the doors of toilets. However there was not personalised signage on people's bedroom doors other than a written name. For people living with dementia it is important to have visual images to help them recognise rooms so that they can find their way around the home and maintain independence.
•□There was limited storage in the home and equipment was stored in corridors presenting a trip hazard.
•□The layout of the building made it difficult for people with mobility issues to walk around independently,

with sloping floors, and small steps in doorways providing obstacles difficult for people with a frame to negotiate.

•There was a small lift for people to use to go upstairs and downstairs. However this was very cramped for someone to use if they were in a wheelchair and also needed a carer with them as well.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

•People were supported to access healthcare. We could see from the records and people told us that they were able to see a GP when they requested.

•We spoke to the GP who said that the home contacted them if they had any concerns and followed the advice that they gave so they had no concerns.

•A chiropodist had been visiting the service on a regular basis. However they had not come when they were last scheduled. At the time of inspection had not visited the home for two months. We asked the provider about this and they told us that there had been some issues as the chiropodist had been unwell, but they had been following this up. On the second day of our inspection the provider told us that they had arranged for another chiropodist to come to the home instead.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Some regulations were not met.

Respecting and promoting people's privacy, dignity and independence

•□At our previous inspection in August 2017 we found that people's dignity was not always preserved and personal information was not always treated confidentially. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our subsequent inspection in May 2018, we found that improvements had not been made and the provider remained in breach of this regulation.

•□The layout of the home made it difficult to maintain people's dignity when having showers. In order to access the wet room people had to go through the dining room and then an office space. On the day of inspection we saw a person being taken on this route in a wheelchair for a shower wearing their dressing gown.

•□People were not consistently treated with dignity and respect. We saw one member of staff become frustrated with an individual with dementia who was repeatedly asking the same question. Another member of staff when supporting someone to eat stood at a distance in front of the person and pointed at the food gesturing for them to eat without speaking to the person or approaching them.

•□People were left sitting in the same place in the living room for most of the day. We did not see staff spending time with people and checking on their welfare, or whether they wanted to move.

•□Feedback from people about whether staff were caring was mixed. When asked, people gave responses such as, "The staff are all right." "The staff will often ask me if everything's all right." "Some [staff] are quite cheerful and caring." Another person told us, "Very good, when they're not too busy. When they are busy, you know about it!"One person told us, "I don't think much of them."

•□People were not consistently supported to maintain their independence. Sometimes people's mobility aids were not left near where they were sitting, preventing them from moving independently. People had equipment to help them to eat independently. For example we saw a person had a plate guard on their plate at lunch time. However the guard was the wrong way round so the person was finding it difficult to eat. A member of staff came to assist them, but then left leaving the person without support to finish their meal.

•□Sufficient improvements to ensure peoples dignity and respect was maintained had not been made.This was a continued repeated breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; equality and diversity; Supporting people to express their views and be involved in making decisions about their care

•□There had been some improvements to care for people. We could see that people had seen the hairdresser and there were records showing when the hairdresser had visited and who had attended.

•□During the inspection we also saw staff being kind and caring. We saw staff supporting someone to walk

with their frame. They were patient and moved at the pace of the person, pointing out any obstacles and showing them the direction to go. We also saw staff respond sympathetically when people were confused. One person asked, "Do I have to go to work today." A staff member reassured them telling them they did not have to go to work today saying, "You can sit here and relax."

•□The level of staffing on the rota impacted on the ability of staff to spend time with people to involve them in their care. Staff told us that it was difficult to find time to spend with people. People told us that they felt some staff listen to them. One person said, "Some [staff] do I suppose…It depends which ones are around as to whether I'd talk to them." There was some evidence in people's care records of people or their relatives being involved in their care plans, but this was not always the case. One relative told us, "The manager here told me it can take a couple of weeks before a meeting can be arranged to sort everything out."

•□We saw records of resident meetings discussing activities, menus and the complaints procedure. However we did not see evidence of feedback being sought to improve the service in any other areas.

•□People's religious needs had been considered and there was a regular church service in the home. However there was no information about meeting alternative religious or spiritual needs.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- At our inspection in August 2017 we found that people's treatment was not personalised to meet their needs this was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At our inspection in May 2018 we found that while improvements had been made there was further work required and the provider remained in breach of this regulation.
- People were left for long periods of time in the living room sitting in the same place. Staff were very task focussed and did not have the time to spend with people on a one to one basis or provide personalised support.
- Care plans and risk assessments were very generic and had not been sufficiently personalised to detail people's individual needs. Behaviour plans for example contained statements such as "act in their best interest" and "support [the person] to remain calm." Plans did not have detail specific to the person, for example what may cause someone to become anxious or upset and what specific action to take to calm someone down.
- We spoke with one person who was noted in their care plan as, "Having problems with [their] behaviours when [they are] feeling distressed and upset." When we spoke to this person they frequently became upset and were experiencing feelings of bereavement about their spouse. However there was no mention of bereavement in the care plan.
- People's needs around personal care were not always met. The home had a 'rota' for people having baths and showers. The care plans we looked at all said people had either a bath or a shower once a week. Staff told us that this was the case, although people could ask if they wanted a bath or shower on a different day. When we looked at the records we could see that some people were recorded as not having had a bath or a shower and had a bed wash instead. We received conflicting information from staff about this. Some staff told us that this was sometimes because people refused the bath because it was difficult using the hoist. Another member of staff told us that the baths were never used and everyone had showers. One person's care plan stated that they preferred to have a bath every week. However their care record stated that the had not taken a bath and the last recorded entry was for a shower two weeks previously. This meant that peoples preferences were not being taken into account in their personal care.
- People and their relatives had not been involved in writing or contributing to the formation of their care plan.
- People's care plans did not reflect their social and work life history. The activities worker had asked people what they would like for activities but no information was available to link activities to people's history. This information is helpful for people providing care because it can help to generate conversation and build relationships with people. It is particularly important for people living with dementia who may not be able to explain about their lives themselves.
- This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

•□We saw some good practice in relation to personalised care. People got up in the mornings when they were ready. On the second day of inspection, we arrived early and some people were already up, but we could see that those who were still sleeping were left to sleep.
•□The handover between shifts included a summary of each individual resident and any changes in needs, incidents or illnesses. These were shared verbally but also recorded in daily notes for each person. For example on the second day of our inspection several of the residents had seen the GP because they had developed a cough. Advice from the GP in relation to each person was shared at the handover.
•□Activities had improved. The activities worker had asked people what activities they liked and put together a programme during the week. They also worked some Saturdays to ensure that there were activities at the weekends. However they had paid for some activities themselves because the provider did not cover the costs.
•□The activities worker had also engaged with the local community. A church service was delivered in the home once a month and also a group from the church came in once a fortnight to do activities and arts and crafts with residents. One person told us, "The church ladies come, and we have music and games – its quite enjoyable."

Improving care quality in response to complaints or concerns
•□There was a complaints procedure in place.
•□The complaints procedure was explained to residents at the resident meetings.
•□People we spoke with told us that they knew how to make a complaint.
•□The provider told us they had received no recent written complaints. He told us that since the start of November they had also started logging verbal complaints from residents. We looked at the record of these complaints and saw that there had been nine verbal complaints from residents which had been resolved either immediately by staff or by action from the provider.
•□The provider told us that they intended to use learning from complaints as part of their improvement strategy.

End of life care and support
•□There was some documentation in people's files about end of life care. This mainly focussed on where people had funeral plans in place and whether people had a do not attempt resuscitation decision (DNAR) in place.
•□In some plans there was information relating to family involvement but we did not see any guidance around people's religious or spiritual needs or preferences for their care at the end of their life.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

•□At our inspection in October 2016 the provider was in breach of four regulations. In August 2017 the provider was in breach of seven of the regulations including repeated breaches for three of the regulations and in May 2018 they continued to be in breach of seven regulations which included repeated breaches for six of the regulations. This included regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
•□Following the inspection in August 2017 we imposed conditions on the providers registration. This meant that they were required to send us monthly reports showing how the quality of service delivered was monitored and assessed.
•□At this inspection we found that sufficient improvements had not been made and the provider remains in breach of six regulations and there was also a new breach of regulation 19.
•□At our inspection and from the monthly reports that we had been sent by the provider we could see that daily health and safety checks were in place. However action was not always taken when issues were highlighted. For example the temperature in the water tanks continued to be below the required 60 degrees centigrade to prevent legionella within the water system. This had been identified as requiring action in our report in May 2018, at this inspection we found that no action had yet been taken,.
•□One of the boilers had been faulty for some time. The landlords gas safety check in May 2018 had identified that the boiler was faulty and needed repair. However this had not been addressed by the provider and over the Christmas period the boiler broke down completely. This left people without heat or hot water in one section of the building at the coldest time of the year. Plug in radiators were used to heat people's rooms and hot water was transported from other areas of the building to wash people in bed. If the repair had been organised following the report by the engineer in May this could have been avoided.
•□At our last inspection in May 2018 we noted that fire checks had identified that some of the automatic door closures on fire doors were not working. At this inspection we found no action had been taken that this continued to be the case. The provider told us that they were taking action to resolve the issue but while it is not resolved this leaves people at risk in the event of a fire. These concerns were reported to the local fire officer.
•□The provider did not keep a record of all safety incidents and near misses. This meant that incidents could not be reviewed and systems changed to prevent them happening in the future. There was no action plan in place to drive improvement following incidents or as a result of concerns highlighted in audits. For example,

incidents where the call bells were not working had not been recorded and therefore there was no action plan regarding improving the reliability of the call bells.

•□We found the provider was not reporting incidents as is required to the local safeguarding authority. During the inspection we identified two incidents which required a referral to local authority safeguarding team. We brought these to the attention of the provider and he made the referral following our inspection.

•□The provider did not always send us the notifications that they are required to send us by law. They did not send a notification when the boiler was not working and we did not receive notifications following the safeguarding referrals that we asked the provider to make.

•□We found that oversight of the service has not been sufficent. There were long periods of time when the provider not present in the service. Of the 237 days since our last inspection the provider had been present at the service on 91 days. This made it difficult for them to observe the quality of care first hand and to develop relationships with people and staff. The provider received regular reports from the administrator and the deputy manager. The deputy manager had left the service the week prior to our inspection and there were no plans in place for the leadership of the staff team.

•□We looked at policies that the provider had in place. We found that these did not provide the guidance required to ensure that staff followed best practice and worked within the law. The Mental Capacity Act policy was not legally correct. It also referred to guidance for nursing when the service did not employ nurses. The health and safety policy was not comprehensive and did not cover all areas necessary in the management of health and safety in care homes. This meant that staff did not have the correct guidance to help them in carrying out their duties.

•□We returned to the service 12 days after our second day of inspection. At this time we found that insufficient action had been taken in respect of concerns we had highlighted.

•□Fire doors continued not to operate properly. Work had been planned in relation to the fire door closures, however there was no contingency plan in place for doors which continued not to close on the sounding of the alarm.

•□No action had been taken to mitigate the indentified risk of legionella from the unsafe water temperatures.

•□The call bell system still did not work and there was no contingency plan in place while the provider looked into upgrading the system to one which was more reliable. This placed people at risk in the event of an emergency as they may not be able to request help, particularly at night.

•□The provider did not have clear oversight of the number of staff required to meet people's needs and support them safely. They used a dependency tool to assess the support that people needed. However it was not clear how this was used to calculate the number of staff on at each shift. The number of staff on duty had not been reviewed as more residents were admitted to the home.

•□There was a lack of contingency planning if staff were ill or absent. One member of staff told us that they had been told to come in to work even though they were not well because the provider could not find cover. The provider told us that they were finding it difficult to recruit and either offered additional shifts to existing staff or used agency staff to cover absence.

•□Staff told us the running of the service had improved since the deputy manager had been in post and there was clearer leadership in place. The deputy manager had left the service a week before our inspection and no contingency arrangements were in place for appropriate leadership in the absence of the deputy manager. The provider told us they intended to recruit a manager and a deputy manager to the service.

•□The lack of clear governance systems was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□At the our inspection in May 2018 we found the provider to be in breach of regulation 20A. This was a failure to display the notification of their rating. They had not put the rating on their website. At this inspection the website was no longer working but the rating was displayed on a noticeboard by the

entrance to the home.

•□The auditing in relation to people medicines had improved. Senior carers audited daily records, including personal care, turn charts, food and fluids etc, although these were ineffective as the senior staff did not identify that charts were not being completed appropriately. However there was no evidence of the provider having oversight of these records and carrying out their own audit checks. There was no oversight of care planning to ensure that it reflected people's needs and was updated when people's needs changed.
•□Staff told us that they had regular staff meetings and these were useful. We saw from records these covered areas such as record keeping, person centred care and employment issues. Some staff said they could raise issues at these meetings. However other staff told us that it was difficult to raise issues with the provider, or if they did raise issues no action was taken and they did not feel listened to. One member of staff told us, "I try to explain things to [the provider] - what is wrong but to be honest he does notfully listen and it goes over his head."
•□Since the last inspection the provider had appointed a consultant to carry out external audits of the service and to help drive improvement. The provider said that they were using this to help them to improve the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•□People attended resident meetings and we could see from these records that people were asked about activities and menu suggestions in these meetings, but there was no wider involvement of people in the improvement of the service. There were no records of surveys of people or their relatives as a way to gather their views about the service and areas for improvement.

Working in partnership with others
•□There was evidence of the service working in partnership with the GP surgery and the district nurse around people's healthcare needs. The activities co ordinator was also working with local church groups to both bring people into the home as well as take people out on trips into the community where possible.
•□We spoke to one professional who works with the home who said that they did not always have the equipment that people needed to support them with their care. They also said that they accepted people who were discharged from hospital when they did not have sufficient staff to provide the care that they needed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care had not always been planned and delivered to meet people's individual needs. Regulation 9 1(a)(b)(c), 2, 3(a)(b)(c)(d)(e)(f)(g)(h)(i)

The enforcement action we took:

We issued a Notice of Proposal to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10 1, 2 (a)(b)

The enforcement action we took:

We issued a Notice of Proposal to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not understand the principles of the Mental Capacity Act. Staff were unclear about whether people had capacity to make decisions and this was not recorded in people's files. Staff did not always seek people's consent before providing them with support. Principles had not been applied correctly when making applications to deprive people of their liberty. Regulation 11 1, 2, 3, 5

The enforcement action we took:

We issued a Notice of Proposal to cancel the providers registration

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

personal care	and treatment Risks associated with the environment had not been assessed and where concerns were highlighted action was not taken to mitigate or remove the risks. There were risks to people's safety associated with people's care needs were not assessed and managed in order to protect people from harm. Not all safety incidents were recorded and action was not always taken to prevent the reoccurrence of safety incidents in the future. Regulation 12 1, 2(a)(b)(c)(d)(h)(i)

The enforcement action we took:

We issued a Notice of Decision to restrict admissions to the care home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems and processes in place to ensure compliance with the regulations associated with the regulated activity. The provider did not take timely action when things went wrong to ensure the safety of people living in the home. Regulation 17 1, 2(a)(b)(c)(e)(f)

The enforcement action we took:

We issued a Notice of Proposal to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not always carry out all the necessary checks when recruiting staff to ensure that they were suitable to work with elderly, frail and vulnerable people in a care home. Regulation 19 3(a)

The enforcement action we took:

We issued a Notice of Proposal to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of suitably qualified, competent, skilled and

experienced staff to make sure that they could meet peoples care needs.

Regulation 18 1, 2(a)(b)

The enforcement action we took:

We issued a Notice of Proposal to cancel the providers registration