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Highnam Hall

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?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 14 and 16 September and 2, 5 and 8 October 2015 and was unannounced. We last inspected the service on 5 May 2015.

We completed an unannounced comprehensive inspection of this service on 27 January 2015 and found the provider was failing to meet legal requirements. Specifically the provider had breached Regulations 9, 12, 13 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our January 2015 inspection we concluded people who use services and others were not protected against the risks associated infection because of inappropriate standards of cleanliness and hygiene relating to the premises. People were not fully protected against the risks associated with medicines because the provider did not manage medicines appropriately. People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate emergency procedures. People were not protected against the risks of receiving care that is inappropriate or unsafe because care was not planned and delivered to meet their individual needs or ensure their safety and welfare.

Summary of findings

We undertook an unannounced focused inspection on 5 May 2015 as part of our on-going enforcement activity and to confirm that they now met legal requirements but we found continued breaches of legal requirements. We found the provider was now meeting requirements in relation to infection control but all other regulations were still in breach.

Highnam Hall is registered to provide residential care to 37 people some of whom are living with dementia. At the time of our inspection there were 30 people living at the service.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had failed to ensure the safety of the building and the premises. There were significant deficits in the electrical safety and fire safety of the building which had not been addressed over a significant period of time leaving people, staff and visitors at risk of significant harm.

We observed a fire alarm activation, which was lacklustre and complacent in that staff did not respond. There was no urgency in the response to ensure people were safe. Staff did not fully check the area of the building where the potential fire was, they left people sitting in the affected zone and made no attempt to evacuate them to a safe area. Fire precautions failed as fire doors were compromised and self-closing doors failed to operate. Fire escape routes were locked; one fire door was locked with a mortice lock which staff took eight minutes to find the key for, fire escape routes through the garden were barred by padlocked gates. This meant vulnerable adults were living in an unsafe building with limited means of escape and staff who were ill equipped to deal with emergency situations.

The provider failed to mitigate risk to the health and wellbeing of people as risk assessments were not robust. They did not identify the risk or the control measures to reduce and manage the risk. Care plans did not provide staff with sufficient detail on strategies to follow to provide people with the care they needed. There were no specific strategies to support people who were living with dementia and may present with behaviour that challenged the service.

Staff observed changes in people's health but we found they did not always refer people for advice and support form health care professionals such as doctors and district nurses.

We observed staff responding to people in an undignified, disrespectful and an infantilised manner when they were distressed and disoriented. Sensitive and confidential information about people's health and welfare was discussed in front of other people during handover which showed a lack of respect for people's privacy. We found staff had not received training in privacy and dignity or in challenging behaviour.

The provider failed to follow the Mental Capacity Act (2005) Code of Practice. We found that where people had lasting powers of attorney there was no paper work to support this and inform staff of what this meant in relation to the care people received. Consent forms had been signed by family members giving care staff the right to act in people's best interests in emergency medical situations. These had no regard to the person's wishes, capacity or whether emergency health care plans or Do Not Attempt Cardiovascular Pulmonary Resuscitation (DNACPR) orders were in place.

The provider failed to ensure robust checks of staff fitness and criminal record check (Disclosure and Barring Service) before they worked with vulnerable people. This meant people were exposed to the risks of being cared for by inappropriate staff.

Complaints were not fully investigated or recorded and we saw no evidence that complainants had been informed of the outcome or resolution to their concerns.

The registered manager failed to ensure an effective system was in place to assess and monitor the quality of care people received. They failed to provide the Commission with information they are required to by law in relation to the notification of incidents of harm. The provider had previously provided the Commission with an action plan saying works would be completed to ensure the safety of the premises by June 2015 however they provided inaccurate information as the Commission found this work had not been completed.

Summary of findings

The provider had an effective system for the safe storage, administration and recording of medicines which was led by the deputy manager and senior care staff.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The electrical and fire safety of the building was inadequate.

People were not protected in the event of an emergency situation.

There were inadequate systems in place for the safe evacuation of people in the event of a fire.

People were not protected from the risks of being cared for by inappropriate staff as robust DBS checking was not in place.

Medicines were managed safely.

Is the service effective?

Inadequate

The service was not effective.

People's rights to be give consent to care and treatment were not considered. The provider was failing to act in accordance with the Mental Capacity Act (2005) Code of Practice.

Staff were not trained to enable them to support people who presented with behaviour that challenged in an effective way.

People were not always supported to access the healthcare they needed.

Is the service caring?

Inadequate

The service was not caring.

People were not treated with dignity and respect.

People's rights to privacy and confidentiality was breached.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not provide staff with accurate, complete, and appropriately detailed information to enable them to provide safe care for people.

Complaints were not fully investigated and responded to.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager failed in their responsibility to ensure effective assessment and monitoring of the service to drive improvement and quality.

There was no managerial oversight or accountability of the service provision evident.

A culture of openness and transparency was not evident.

Highnam Hall

Detailed findings

Background to this inspection

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

This inspection took place over five days. The inspection took place on 14 and 16 September and 2, 5 and 8 October 2015 and was unannounced which meant the provider and staff did not know we were coming.

The inspection team consisted of four adult social care inspectors, a specialist advisor in electrical installation and emergency lighting 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. The Fire Service also conducted an inspection on the 8 October 2015.

Prior to the inspection we reviewed information we held about the home, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

During this inspection we spoke to nine people who live at Highnam Hall and four relatives. We also spoke with the registered manager, the deputy manager, three senior care staff, the cook, the activities co-ordinator, the area manager and nine care staff. We also spoke with the buildings manager and the contracted electricians.

We carried out an observation using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We undertook general observations of how staff interacted with people as they went about their work.

We looked at five people's care records and six people's medicines records. We examined six staff files including recruitment, supervision and training records. We also looked at other records relating to the management of the home including building safety, health and safety, quality assurance and complaints.

Inadequate

Is the service safe?

Our findings

During the comprehensive inspection on 27 January 2015 and the focused inspection of 5 May 2015 we found the service was not safe. This was because the provider had not protected people against the risks associated with unsafe or unsuitable premises because of inadequate emergency procedures.

The home did not have adequate emergency procedures in place. We reviewed fire safety care plans and on each one, only five out of 40 care and ancillary staff had signed as an indicator that they had read and understood the plan as required. We noted care plans were not specific to the person and contained generic statements. This meant it was not clear what knowledge staff had or if they would know how to support each individual person in the case of a fire.

We observed management and staff reaction to a fire alarm activation during our inspection. Staff proceeded to the meeting point at the main entrance to the building. At 11.14am the deputy manager checked the fire panel which indicated zone five and dispatched two care workers to check the back lounge. The care workers returned and stated that there was no fire in the back lounge. The alarm continued to sound. It was not established if it was a fire or a false alarm. We did not observe the senior person in the building taking charge. At 11.20am a Fire Officer from the Cleveland Fire Service, who was present undertaking an inspection, took charge of the situation and went to investigate the whole zone as detailed in the service's emergency procedure. They returned stating they thought it was a false alarm. The alarm went off on two further occasions with no staff response.

Throughout the whole fire alarm activation no attempt was made to conduct a roll call of people using the service and only a visual one of staff and visitors was conducted. This placed vulnerable people at risk of exposure to harm or actual harm. We noted a number of self-closing doors failed to close this meant people would not be protected against smoke inhalation or heat exposure in the event of a fire.

The deputy manager explained the fire evacuation procedure as, "Alarm, go to front, check zone. Two staff go together to check the zone, tell senior who phones 999." We noted that at no point did any senior member of staff telephone the emergency services.

We looked at the home's fire zone plan. This is used for people to understand the layout of the building and to see where fire exits and extinguishers are located. We found the fire zone plan was out of date and did not reflect the changed usage of some rooms or the change in locations of the fire extinguishers. The plan was also identified as being out of date at the inspection in January 2015. We found the last fire safety inspection had taken place in April 2014. The inspection found the home's safety systems to be "unsatisfactory" in a number of areas.

The deficits identified in the electrical installation report of 31 March 2014 had not been rectified; this included dangerous and potentially dangerous deficits. This was also identified in our inspection of 5 May 2015. We reviewed a fire detection and alarm system inspection and servicing report dated 27 July 2015 and an emergency lighting periodic inspection report of 27 July 2015. Both these documents identified significant deficits which placed people at risk of harm. It was not clear that following either of these inspections that actions had been taken to minimise this risk or bring the systems up to standard.

Following the inspection by the Cleveland Fire Service on 08 October 2015 the provider was issued a notification of fire safety deficiencies action plan which identified a significant number of failings of fire protection within the building. This included fire doors which did not close and had holes in; self-closing doors which did not activate when the fire alarm sounded; escape routes which were locked and gates which were padlocked, an unsuitable fire safety risk assessment and inadequate fire safety training for staff.

This meant there was a risk that people could not leave this area safely because there were obstacles that could slow down an evacuation. We concluded that all of the concerns in relation to the electrical works, fire detection system, emergency lighting system and staff evacuation placed people, staff and visitors at significant and serious risk of harm should there be a fire.

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

Inadequate

Is the service safe?

Risk assessments in relation to people were integrated in the care plan files under a section headed, 'Risk assessment/management.' This information did not robustly and clearly identify risks, nor was there a clear record of the control measures staff were to follow to minimise risk to the person, themselves or others. It was identified in the inspection of 27 January 2015 that risk assessments were not specific nor did they identify the controls needed to manage risks.

For one person it was noted that they had been known to 'pretend to bang their head off a wall.' The risk assessment/ management stated 'If the staff fails to document the behavioural changes accurately then I am at risk of not receiving the correct medical assistance to aid in a happy and comfortable lifestyle. I am at risk of deterioration of my mental health and become more confused it staff fails to involve the correct professional intervention required.' The risk assessment did not identify any risks to the person, staff or other people in relation to the behaviour described in the care plan which included 'pretending to bang their head off a wall,' 'storming out,' and becoming 'verbally aggressive.' There were no control measures identified in relation to how to minimise the risk that the person may become challenging. This meant the provider had failed to mitigate risk.

The service had an accident book, and accidents and incidents were audited on a monthly basis. This logged the total number of incidents, the number requiring external professional intervention and 'comments/actions taken'. Accident reports were not always fully completed. For example, one record contained details of a person having an unobserved fall that resulted in a mark to their head and which resulted in observations being carried out. The 'lessons learned' section of the report was blank. Another record detailed an unobserved fall where a person had attempted to move some furniture which had broken apart and resulted in them losing their balance. A referral was made to the falls team, but the 'comments' section was left blank and there was no investigation of the condition or safety of furniture at the service. This meant it was not possible to see if lessons had been learned.

The registered manager said, "There's a trend analysis on the accident and incident report. There are lessons learnt that [deputy manager] looks at. Do know we need lessons learnt and action plans, we should be putting them in." We saw minutes of a health and safety meeting from 01 July 2015 which noted, 'Accidents in the home are currently not being looked at overall as a group for patterns. Managers will still be responsible to ensure their own analysis are completed.'

The provider had a safeguarding policy in place, which contained information on safeguarding issues for staff to look out for and how they should be reported. This was displayed in communal areas throughout the service, and contact details for the local safeguarding unit and police were also advertised. Staff were expected to read the safeguarding policy and sign to confirm they understood it. The policy had last been signed in 2012. We asked the deputy manager about this and were told, "The policy is discussed in training and staff meetings and supervisions. They should have signed the policy".

Staff had a working knowledge of safeguarding and could identify possible forms of abuse. One said, "If I had suspicions I would go to the most senior person, unless it was about them at which point I would go up the chain."

We found records of investigation of safeguarding incidents were not always complete, which meant that it was not possible to see if lessons had been learned. In one, the 'Action Plan' section of the 'Safeguarding Alert Procedure' form was left blank. In another, there was a 'Lessons Learnt Log' which listed conclusions drawn from an investigation but did not list any remedial action taken.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We examined six staff recruitment files. In one file we saw a job description, but there was no evidence of a job application form, references or Disclosure and Barring Service (DBS) check. In another file we noted the member of staff had started employment 8 September 2015 however their DBS was dated 7 August 2013. This meant the registered manager had not ensured a DBS check specific to the staff member's employment at Highnam Hall had been completed. We found this was the case in other three staff files, which meant people, were at risk of being supported by staff who had not had appropriate checks completed on their criminality. The registered manager told us, "I thought as they have transferred from [another of the provider's homes] I didn't have to get DBS checked."

Inadequate

Is the service safe?

DBS checks help employers make safer decisions and help to prevent unsuitable people working with vulnerable adults. This meant the registered manager did not understand safe recruitment practices.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were assessed using a 'Staffing Level Policy' based upon people's individual support needs. Staffing levels were assessed on a weekly basis, and people's individual support needs were reviewed monthly. Records showed that changes in people's support needs were noted (for example, '[Service user] returned from hospital') and consideration was given to the impact on staffing levels.

During the day there were six care staff, including a senior carer. At night there were two care staff, and a senior carer. One member of staff said, "It can be busy but staffing is fine I think." Another said, "I think we have enough staff on shift." We questioned if the current staffing configuration was adequate for the current client mix. For example, of the 30 people, 16 were identified by staff as requiring two staff to assist with personal care.

We found some improvements to the management of medicines. We examined medicines administration records (MAR) for six people using the service. The provider used a bio dose system of administration, where all medicines due at a specific time is contained in one blister pack. Each individual pod is labelled with the people and drug information and the perforations in the seal allow individual doses to be pushed up and out of the tray, ready for the dose to be taken.

The MARs we viewed showed no gaps or discrepancies. Where medicine was not administered a code was recorded to indicate this. There were clear as and when required (PRN) protocol for each person.

Medicines were stored in a locked room, and dispensed from three steel lockable trolleys. We noted three liquid medicines which had been opened did not have the date open recorded on the bottle. We made the senior carer aware of the issue and they immediately destroyed the medicines and completed the appropriate documentation.

The provider maintained accurate and up to date records for the receipt and disposal of medicines. The provider also had accurate records relating to the management of drugs liable to misuse (controlled drugs). Two people who used the service were receiving their medicines covertly (without their knowledge). The provider had the required documentation in place for this decision, which had been made jointly with staff and the person's GP. We observed senior care staff during medicine rounds. We noted they treated people with respect and give people time to take their medicines.

Inadequate

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find.

We saw the first floor rear corridor leading to bedrooms was accessible via a key pad only. We asked the deputy manager about this who said, "People are told the code, some people will ask staff. A couple of ladies who spend all or a lot of time in their rooms. People who wander had a tendency to go in people's rooms." We asked about the impact of this on people's liberty and were told, "Some do and some don't have DoLS." The deputy manager went on to say, "A further 10 or 8 people have rooms down there, they are told the key number but don't remember it so they need to ask staff." We concluded that the key pad entry system deprived people of free access to their bedrooms.

We saw consent forms signed by people's relatives which gave staff at Highnam Hall consent to act in the best interest of the person with any emergency medical intervention when required. There was no supporting mental capacity assessment to indicate whether people had capacity to make these decisions in advance. We saw no information in regard to whether people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPRs) or emergency health care plans in place, nor was the information cross referenced to anyone having a lasting power of attorney for health and welfare.

We saw one person had a Deprivation of Liberty care plan which stated an authorised Deprivation of Liberty Safeguards (DoLS) was in place until 01 October 2014. The care plan was dated 24 June 2014. A care plan review dated 26 May 2015 noted that a DoLS was in place which expired on 29 July 2015. We asked the registered manager about this who brought a DoLS file and said, "There's a log to indicate it was sent on 02 July 2015 [for renewal]." We did not see any evidence of the application form to extend the DoLS application. The registered manager went on to say, "We have a plan for re-doing care plans but obviously [persons] hasn't been done yet." The deputy manager later confirmed a DoLS request had been sent to the local authority via email and they showed us the authorisation which was in place until July 2016. They said, "A lasting power of attorney was put in place but there's no paperwork to support it."

We saw another person had a Do Not Attempt Cardio Pulmonary Resuscitation order (DNACPR) in place which stated there was a personal welfare lasting power of attorney or court appointed deputy or Independant Mental Capacity Advocate in place who had been consulted about the decision. We saw no evidence of who had been appointed.

People had, 'Capacity assessment summary sheets' in their care records. One person's was dated July 2015 and stated, 'My family makes all major decisions,' we saw no documentary evidence of a capacity assessment, best interest decision or Lasting Power of Attorney (LPA) to support this. This meant the provider was failing to follow the MCA (2005) Code of Practice. There was a record to say the person's family member held a LPA for the person. We asked the registered manager if they had a copy of the LPA, they said, "If it's not in the file no." We asked what the LPA was in relation to and they said, "It must be health and welfare as the council deal with finances." This meant the provider could have breached the LPA as they did not have a copy so were unaware of the decision making rights held.

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

The service had a 'Refresher training schedule'. We noted the majority of mandatory training was up to date, including safeguarding adults, fire safety, moving and handling and mental capacity.

Four staff were overdue in Moving and Handling training. We asked about the gaps and the deputy manager said, "We're [the registered manager and deputy manager] both responsible for training."

We noted the training matrix did not detail care plan training or behaviour training. We asked the deputy manager about care plan training. They said, "No external care planning training, we've not found any because they are specific to people. We all know what needs to be in them." They added, "We asked social workers what they need, want in them as well." We asked the registered manager about challenging behaviour training, They said, "We are waiting for it be sourced." During the inspection of 27 January 2015 it was noted that staff told us they would like extra training in how to support people with complex needs.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

We viewed the supervision and observation matrix and noted some staff had not had supervision in 2015 but observations had taken place. Supervisions are a means for management to assess staff competency and knowledge in the delivery of their role. We noted staff were competing question sheets in response to medicines and mental capacity but there was no meaningful assessment of competency was evident.

People told us the food was good and there was plenty to eat. A pictorial menu was on a wall in the dining room. We saw people having breakfast late morning and one person told us, "I like to stay in bed." When the meal was served people were not told there was a choice and only one person said they could not eat the main meal. This person was then offered an alternative.

Standard supporting tools such as Malnutrition Universal Screening Tool were used to assess people's risk of malnutrition.

We noted that some people had 'new sore forms' which were completed if staff noticed any change to people's skin integrity. One person had a form which was dated 24 June 2015 which recorded, 'Purple blotches apparent on both legs.' Observations charts were in place from 4 October 2015 which stated, 'remains dark.' We saw that the professional contacts sheet recorded contact with the district nurses but this was recorded as being for concerns over the person's continence needs and a pressure sore to their hip rather than to their legs.

We saw evidence in other care records of cooperation between care staff and healthcare professionals including social workers, dietetics, pharmacy, community psychiatric nurses, occupational therapists, physiotherapy, and GPs to ensure people received effective care. For example, one person had been referred to the falls team following a series of falls.

Inadequate

Is the service caring?

Our findings

We completed an observation of meal times and noted the dining tables were set with a tablecloth which was covered with an oil cloth, some tables and chairs were dirty with dried food. No condiments were available on the tables. A couple of people had to ask for sugar which staff provided by the spoonful.

Eight people had their meal in the dining room and staff assisted people to the tables. We noted staff placed a bib on one person without asking the person if they wished to have one. The meal was placed in front of the person without any interaction from the care worker.

We observed that people were left for long periods without care workers supporting them. The cook chatted and encouraged people to eat their meals and assisted people when asked.

One person's care plan advised staff they needed to encourage the person to eat. The person was given their meal and left alone. A care worker returned twice and offered encouragement then removed the plate without explanation. This meant the person may have been at risk of their nutritional needs not being met.

We witnessed at breakfast time a care worker sitting between two people, attempting to support both with eating at the same time. We observed they offered one mouthful for one person then the other. The speed and offering of the meal was dictated by how quickly the other ate their mouthful. This was undignified and disrespectful.

This meant appropriate support and attention was not always provided so people had a pleasant dining experience.

We observed a morning handover where night staff discussed each person and how they had presented overnight. The handover was held in the dining room and we noted that one of the people who live at the service was in the dining room waiting for breakfast whilst staff had the handover. Staff mentioned people's names and shared personal information about personal care needs, behaviour, medicine management and skin integrity. This meant peoples dignity and privacy was not respected as sensitive information was discussed in front of other people.

We noted some of the language used in care plans was disrespectful and judgemental, such as 'I will storm out the dining room.' We observed two care workers supporting two people who were displaying behaviour which was challenging to each other. The care workers intervened by asking one person to be quiet and the other to go to the lounge. We didn't observe any specific strategies used but one person did move and was supported to the lounge. The care worker then returned to the person and said, "Are you going to go to your room now to calm down." We observed the person was calm and this escalated the situation as the person became distressed as to why they were being told to go to their room to calm down. We later heard the same care worker telling the same person, "Are you going to behave today." We concluded this interaction was infantilisation, that is treating someone in a patronising way as if they were a small child.

We noted a used continence pad was on the floor of the ground floor toilet on the 02 October at 11.55 am. At 2.15pm this had been removed and the bathroom was clean. We also saw in the first floor lounge/library we noted there was an open bag of continence pads on top of one of the shelves which were there throughout the period of the inspection.

Whilst speaking to one person on the rear first floor corridor a staff member joined in the conversation and asked the person if they had had breakfast. At this point another carer opened the bathroom door, whilst supporting someone, and told us that they had already had breakfast. The staff member continued chatting with the bathroom door open whilst another person was inside the bathroom. This meant the staff member was not maintaining the person's privacy or dignity and potentially left them vulnerable to harm.

Out of 40 staff 32 staff had not completed or were not booked in for Equality and Diversity training and 33 had not completed nor were they booked to attend End of Life care training

This was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014

On 2 October 2015 one person who was sitting in the lounge waved to us and said they were cold, another person was nodding in agreement and we noted a third

Inadequate

Is the service caring?

person was huddled up, pulling their clothing close around themselves giving the impression that they were also cold. We told the registered manager, who said they would deal with it.

There was some advocacy information in the home but it was not displayed in an easily accessible area for people or visitors.

We saw four people had their meal in the lounge, two required supervision but were encouraged to eat on their own which they did, and two required supporting with eating and this was done by two carers.

The service had a dementia champion in post who had recently completed training. We found them to be enthusiastic and observed they interacted in a patient and reassuring manner with people.

Inadequate

Is the service responsive?

Our findings

During the comprehensive inspection on 27 January 2015 and the focused inspection of 5 May 2015 we found the service was not always responsive. This was because the provider had not protected people against the risks of receiving care that was inappropriate or unsafe because care was not planned and delivered to meet their individual needs or ensure their safety and welfare. In particular care plans did not contain up to date and relevant information such as specific strategies to support staff with managing behaviour that may challenge the service.

During our recent inspection we reviewed peoples care records and found that some care plans had been rewritten by the registered manager and the deputy manager. We found they still lacked specific strategies for staff to follow; there were discrepancies in information and some contained judgemental statements.

One person had a document called 'This is Me.' This included some personal information about the person such as their need to be supported by one member of staff with their mobility due to being unsteady. We later saw a moving and handling risk assessment which stated that the person was at high risk of falls. There was no information on how this assessment had been made. In relation to transfers the document had a tick next to 'assistance required'. It then said one or two staff to support with transfers depending on the person's 'behaviours.' There was no other detail for staff to use to assess whether support should be provided by one or two staff. The information was incomplete and therefore left the person at risk of receiving care that did not meet their needs; staff were also left vulnerable to harm.

The walking assessment had a tick next to assistance required and a cross next to stairs with a note stating lift to be used. The mobility care plan did not indicate any circumstances where two staff may be needed for support. The information stated, 'Staff can assist me in sitting by explaining to me I maybe need to sit down to reduce the risks.' This person is living with dementia and it was recorded they needed staff to use simple sentences as they become confused with conversation. This meant the person may not understand the concept of risk if spoken to using those words. We concluded that the information contained in the care record was contradictory and insufficient to enable staff to care for the person in a safe, consistent and person centred way.

The same person's mobility care plan stated, 'I have refused any equipment advised by occupational therapy due to my confusion. I am unable to understand the instructions.' There was no information on the equipment the person had been assessed as needing or any strategies that either had been or could be used to support them to use the equipment. This meant the person and staff were left vulnerable and at risk.

The same mobility care plan stated that the person could wander during the night so staff should offer two hourly safety checks. The person had a bedroom on the first floor of the building with access to stairs. The care plan stated they were and was at high risk of falls and should not be using stairs. At 6.00am on the 2 October we viewed the night check sheet, the last check was completed at 1.30am this meant the person had not been checked for four and a half hours. We concluded that staff were not following the care plan which left the person vulnerable and at increased risk of falls.

On our early morning inspection on 16 September we found night staff had recorded checks before they had taken place. Records showed incontinence assistance was given, safety checks had been completed and that whether people were awake or a sleep. We asked staff if these checks had been conducted they confirmed this was not the case and were about to do them. This meant people were at risk of neglect due to staff recording continence checks had been completed when in fact they had not. We immediately made the area manager aware of this and the provider is investigating into the incident.

We viewed another person's night time check sheet which showed they needed two hourly safety checks and four hourly 'turn and inco' checks. The last recorded check for this person was recorded at 12.50 on 2 October; this meant the person had not been checked for over five hours. Another person had a turning chart for the 2 October which was blank. This meant it was not clear whether staff were completing night checks as required, which placed people at risk. We asked the registered manager how they monitored that night checks were being completed. They said, "It was brought to my attention yesterday that I need to come in and do some checks early morning."

Inadequate

Is the service responsive?

One persons 'This is Me' document stated the person can become confused. It went on to say, 'I calm down with distraction skills and reassurances from the staff.' There was no indication in this document of the strategies staff should use to distract and reassure the person. There was no specific care plan around support with behaviour but the plan titled 'Capacity (vascular dementia) did state, 'I can shout at the staff and become defensive with personal care.' It went on to record 'Staff need to be understanding of my illness offering support, encouragement and try to explain slowly (so I can process) what you are asking. Staff need to use simple sentences.' It stated, 'when having conversations I am usually confused with this and in the middle of a conversation I will start another confused conversation.' There were no clear strategies recorded for staff to follow to support effective communication such as the use of pictures nor was there any information for staff about how to support the person if they started shouting or became distressed during personal care. There was no description of what 'defensive' actually meant.

Further information about the person's behaviour was in the toileting and continence care plan. It stated, 'I can become resistive I can push staff away or even grab at staff if I don't understand why I seem to have become resistant with the whole bathroom area especially with personal intervention.' This statement indicates the person needs to understand why they have become resistant to this aspect of their care rather than the staff needing to understand what strategies to use to safely support and reassure the person. The plan goes on to state, 'Two staff are needed to assist with this intervention as I will hit staff and push staff away.' There is no recorded information on what support the two staff should be providing. The lack of strategies to follow leaves the person and the staff at risk of harm. The plan does state that staff are to remember to follow the person's personal plan of care around aggressive behaviour during personal intervention.

We saw no evidence of a personal plan of care around aggressive behaviour. The use of the words 'aggressive behaviour' is judgemental and shows limited understanding of the needs of people living with dementia. We did see a 'personal care' care plan which stated, 'If the person became agitated and it was safe for staff to do so they were to leave the room and request another staff member to assist.' It also stated, 'This can sometimes help me stay calm.'

The risk assessment/management part of the toileting and continence care plan stated the person uses incontinence pads but the care plan itself does not state this. There is no reference to the continence nurse or the type of aids the person needs to use.

In order to get a full picture of the persons needs in relation to their behaviour and personal care staff would need to read an array of care plans and piece the information together. This meant staff may not read or may not take on board all the information due to the disjointed nature of the care plans which may leave staff and the person vulnerable to receiving inconsistent, unsafe and inappropriate care leaving them to vulnerable to harm.

We viewed one person's behaviour care plan. The initial step for staff to follow was recorded as, 'For staff to be aware that I can demonstrate of [person's name] present time behaviour and understand it to the best of their ability.' We found that it was not clear what this statement meant. Some triggers were identified such as the person sleeping late and, 'If I have to wait one minute for a cup of tea.' It was recorded that the person could become verbally abusive or 'storm out' and that they had 'Previously pretended to bang my own head off the wall.' Staff were to intervene by asking what was wrong and that staff 'Will sort things out.' It then went on to say, 'Any changes that develop that is unusual for me needs to be documented on the chart that is in the SPARD file.' We asked about the SPARD file, the deputy manager said, "None have ever been done." We asked what would trigger it and they said, "Anything unusual or beyond normal." They added, "It needs to be in the care plan, I agree that information isn't there, we need to describe what it looks like so we all know. [Person] de-escalates by leaving the room and because of their short term memory loss they come back and is fine."

We saw other care plans that were not specific and could place people at risk. One person's eating and drinking care plan stated, 'I do need some food cut up.' There was no information on whether this related to specific food, how small the person needed the food cut or whether the person was able to ask for staff to do this if they were in need of support. Their nutritional needs plan stated, 'Staff need to offer support during my mealtimes and assist with feeding at these times.' There was no information on the specific support the person needed.

Progress and evaluation sheets were completed each month. The reviews detailed changes to people's

Inadequate

Is the service responsive?

presentation and support needs such as, 'Staff must encourage [person] to use the toilet, go for meals.' However, this information did not routinely lead to a new care plan being put in place. For this particular person's care plan titled 'capacity (vascular dementia)' the steps to follow read as the person's journey through dementia rather than a plan of care that staff should follow.

We spoke to the deputy manager about care plans as previous inspections had found concerns. They said, "[registered manager] took over care plans when she returned. We've met with commissioners and have a way forward." They added, "We are working with [person's name] from commissioning. They have been giving advice that we've followed." They explained that the target was to re-do all care plans. They said, "The original time frame was 16 October but with the new style we are going to sit down with [name of area manager] for a new time frame." The breach with regard to care records was first reported on during the inspection of 27 January 2015 and action to remedy the breach was still not complete eight months later.

This was a breach of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints file was in place and included a complaints procedure which included time frames for acknowledging and resolving any complaints. A verbal complaint had been received in May 2015 in relation to a person's diet and fluid intake. The staff member had explained the person was 'having an adequate intake which varies from day to day.' The complainant also raised concern about the condition of their relative's skin and people's general appearance. It was recorded on the form that a telephone call from the deputy manager had been arranged but we noted there was no further information recorded in regards to the outcome or resolution of the complaint.

This meant there was no record of the action taken to investigate the complaint. There was no record of action taken or the resolution achieved, nor was there confirmation that the complainant was satisfied with the outcome of the complaint.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a programme of activities on display but we found this was not being implemented. The activities co-ordinator explained this was because people were not interested. As an alternative they were implementing one to one activities which were trips to the local supermarket. People had activities care plans but we saw no attempt to engage people with individual interests and hobbies.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager. During the inspection we found that the registered manager was not fully aware of their responsibilities.

We found that the registered manager had failed to submit statutory notifications in relation to safeguarding concerns. Notifications are changes, events or incidents the provider is legally obliged to send us. The registered manager said, "I would send notifications in but thought as the local authority weren't going to look at them I didn't need to send them in."

We also found the registered manager had failed to display the most recent rating by the Commission of the service providers overall performance.

Action was taken outside of the inspection process in relation to this.

We asked the registered manager and the buildings manager about works completed in relation to the safety of the premises (as detailed in safe). They both confirmed that work had not been completed even though an action plan sent to the Commission stated work would be finalised by June 2015. The provider failed to show candour, honesty and transparency as they did not keep the commission up to date with lack of progress in this area.

The registered manager did not appear to acknowledge the areas of concern we raised. On the 2 October 2015 they worked as a senior carer and delegated their management responsibilities to the deputy manager. The registered manager referred to action taken by the deputy manager on several occasions. On 8 October during the Fire Service inspection the registered manager did not engage with this process, the building manager walked around the service and heard the outcome.

We asked the registered manager how they monitored that night checks were being completed. They said, "It was brought to my attention yesterday that I need to come in and do some checks early morning." They said, "The area manager is coming in early mornings to speak to staff about them."

The area manager's site visit report which was completed in 30 July 2015 noted that the registered manager had advised that health and safety checks had not been completed since their return to the service in June. There was an action point that the registered manager should complete health and safety checks or should ensure they were completed if the task was delegated. The time frame for this was one week. We saw no evidence that health and safety checks had been completed by either the manager or any other staff member.

We noted a fire risk assessment was in place and had been reviewed by the Registered Manager. We asked them about the review and they said, "I missed out on the health and safety training," they went on to say, "No I haven't had any proper training, I completed the fire risk assessment with [name of the buildings manager].

We saw records from a health and safety meeting held on 1 July 2015. A reference was made that, 'All managers are responsible for the health and safety of their premises.' The registered manager said, "I am aware of the electrical engineering. [Name of building manager] has been working on the project, the electricians are reporting to him." They added, "I wasn't here when the action plan was requested, I haven't completed that work, we were waiting for the building manager to come in place." The building manager came into post July 2015 and at the time of the inspection there was still no evidence that the work was completed. This means the registered manager had no oversight of the building and premises safety and action plan and was therefore neglectful of their responsibilities as the registered manager.

We asked the registered manager about care plan audits, they said, "Not done yet." They then said, "I try to look at one care plan a day. I have a care plan audit." We asked to see this, and they said, "I'll have to ask [name of deputy manager] where they've put it."

The matrix was located and the registered manager said, "From end of June to now I re-done 17 care plans. Council are disputing care plans now so I'm meeting with them on [date] to go through a care plan." They went on to say, "[commissioners names] and [name of the deputy manager] understand it better than me."

One person's care records contained a care plan audit tool. We noted the document had been completed by the deputy manager but it was not dated nor had it been completed in full. Some action were recorded such as, 'Needs new pen picture; does not wear teeth or glasses; all new care plans added.' The audit did not include who had been assigned tasks to complete nor a time frame for

completion. As it was not dated it was difficult to assess if actions had been completed, but we noted the pen picture had hand written comments on it and some information was crossed out which indicated work had not been fully completed.

We concluded this was not a robust audit tool as it was not being used to effectively audit care plans and drive improvements.

We saw care plans included post it notes and pieces of paper with additional comments on them such as contact numbers or updates to care plans. This was not an effective way of recording important information as the notes could have fallen from the care record files which meant staff would be not have the most current information about the person.

Some care records contained a sheet headed, 'Please sign and date once all care plans have been read and understood.' We noted these had not been completed; one person's had been signed by two staff on the 26 June 2015 and the 08 May 2015. There were 36 staff names on the list. This had not been picked up on the persons care plan audit tool.

We saw a file which was titled, 'Senior check lists.' This file contained a document title, 'Senior staff check list,' which included, for example, temperature checks for the fridge and rooms; continence charts, supervisions, fire safety, wheelchair checks. Staff put a tick next to checks presumably to indicate that they had been completed but we noted several days were there were gaps in the recording of these checks. There were no signatures on the checks, nor was there place to record any action or comments. The check list we saw only ran up to the 20 September 2015. We asked the senior care staff member about this who said, "There is another one, I think [registered manager] has it as she doesn't normally do senior shifts."

The registered manager explained to us that she was working one senior care shift a week. They explained to us that it was thought by the senior managers that they were spending too much time in the office and needed to know where things were. We noted on the day the registered manager was working a senior care shift, they were not wearing the senior uniform and there was no other manager due on shift to manage the service until the deputy manager was called in by the provider of the service from a day off to support the inspection process. We also noted the senior care staff who was on shift from 9am to 12 noon to administer medicines was still in the building at 2.00pm. We did not observe the registered manager complete any direct care or support of people.

The bowel chart which was kept in the senior check list file hadn't been updated since 30 August 2015; the handover of medicine keys was not routinely signed by two staff and the log for the calibration of scales had not been completed since June 2015. We noted there was no evidence of any managerial review of these documents which meant gaps in checks were not being monitored or addressed.

We saw that surveys were sent to people, relative's and staff but there was no overall analysis of the results, therefore we could not be certain this was an effective tool to consult with people and drive forward continuous improvements.

We concluded there was no safe governance process in place for safe recruitment; the registered manager did not understand their responsibility in relation to ensuring vulnerable people were protected from the risks of unsuitable staff caring for them. We also concluded there was no robust or effective system in place to ensure the effective management of the service. There were no effective quality assurance or audit systems in place to assess, monitor and improve the quality and safety of the service.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was provided in a safe way for people. People were not protected against the risks of receiving care that was inappropriate or unsafe because care was not planned and delivered to meet their individual needs or ensure their safety and welfare. The provider did not ensure the premises used by people were safe to use for their intended purpose. Regulations 12(1); 12(2)(a); 12(2)(b); 12(2)(c); 12(2)(d).

The enforcement action we took:
We issued a section 31 Notice of Decision on 13 October 2015 to impose a restrictive condition to prevent the home carrying on the regulated activity of accommodation for persons who require nursing or personal care, until the provider is compliant with the Health and Social Care Act (Regulated Activities) Regulation 2014 12 and that works are completed and certified by accredited professionals.
We took enforcement action which resulted in the cancellation of the providers registration.

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 an effective and robust system in place to assess, monitor and improve the quality of the service provided. Regulations 17(2)(a); 17(2)(b); 17(2)(c); 17(2)(f)

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider did not make sure people were treated with dignity and respect.

This section is primarily information for the provider

Enforcement actions

Regulations 10(1); 10(2)(A).

The enforcement action we took:
We took enforcement action which resulted in the cancellation of 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 acted in a way which breached the Mental Capacity Act (2005) Code of Conduct. Regulations 11(1); 11(3)

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider failed to investigate and record the outcome of complaints. Regulations 16(1): 16(2)

The enforcement action we took:
We took enforcement action which resulted in the cancellation of 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 failed to have robust and effective recruitment practices in place. Regulations 19(1)(a); 19(5)

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA (RA) Regulations 2014 Requirements relating to registered managers **The registered person failed to demonstrate the appropriate knowledge of applicable legislation.** Regulations 7(2)(b)

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.

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 **The registered manager failed to ensure an effective system for investigating immediately upon becoming aware of any allegations or evidence of abuse.** Regulations 13(3)

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments **The provider failed, without reasonable excuse, to display the rating of performance by the Commission.** Regulation 20A

The enforcement action we took:
The provider was issued a fixed penalty notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider failed to notify the Commission of incidents without delay.** Regulation 18(1); 18(2)(e); 18(2)(f)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
The provider was issued a fixed penalty notice.