Higher Park Lodge Limited

Higher Park Lodge

Inspection report

Devonport Park
Stoke
Plymouth
Devon
PL1 4BT
Tel: 01752 606066

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Ratings

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

Overall summary

The inspection took place on 27 and 29 May 2015 and was unannounced.

Higher Park Lodge provides care and accommodation for up to 34 people who are living with dementia or who may have physical and mental health needs. On the day of the inspection 33 people were living at the care home.

The home is on three floors, with access to the lower and upper floors via stairs or a passenger lift. There are shared bathrooms, shower facilities and toilets. Communal areas include a lounge, a reading room, dining room and outside patio area.

At our last inspection in July 2013 the provider was meeting all of the Essential Standards inspected.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People told us they felt safe living at Higher Park Lodge. People were protected by safe recruitment procedures as all employees were subject to necessary checks which determined they were suitable to work with vulnerable people.

Staff understood how to recognise abuse and knew what their responsibilities were. However, people were not always protected from abuse because the provider did not have an effective system in place to investigate allegations of abuse. People received their medicines, but people's medicines were not effectively managed. Medicines were not always stored safely and documentation relating to medicines was inaccurate.

There were enough staff to meet people's needs. People's feedback about staff varied, some people told us staff were kind whilst others felt differently. We observed a mixed approach by staff, some staff showed kindness and compassion whilst others did not. People's confidentiality, privacy and dignity were not always respected. Locks on bathroom doors did not always work, information about people's individual care needs were displayed on people's wardrobes or on their front door to their bedroom and conversations between staff about people were not always held in private.

Staff told us they felt well supported by the registered manager and deputy manager. Staff received training and supervision to carry out their role, but some staff had not undertaken specific training to meet people's needs, such as dementia care and manual handling.

People were not protected from risks associated with their care because staff did not have the correct guidance and direction about how to meet people's individual care needs. The registered manager and staff did not fully understand how the Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS) protected people to ensure their freedom to make decisions and choices was supported and respected. This meant decisions were being made for people without proper consultation. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

People experienced a disorganised approach by staff at lunch time, and people who required support with their meals did not always receive it. People were not always given choices about what they would like to eat and drink. People who were at risk of not eating and drinking enough were not being effectively monitored, which meant concerns may not have been identified quickly. People were not able to help themselves to drinks when they needed them as they were not always readily available.

People did not always have care plans in place to address their individual health and social care needs. People were not involved in the creation of their care plan. People's changing care needs were not always communicated amongst the staff team, which meant referrals to relevant health services were not always made in a timely manner.

People's care plans were not individualised and did not provide guidance and direction to staff about how to meet people's care needs. People told us there were not enough activities or opportunities to go out.

People's end of life wishes were not documented and communicated. People's care planning documentation was not reflective of their wishes. This meant people's end of life wishes were not known to staff.

People who were living with dementia were not always appropriately supported in a person centred way. People's care plans did not address dementia care needs and demonstrate how they would like to be supported. The environment was not designed to empower people living with dementia, because of poor signage and a lack of colour contrast.

People and those who mattered to them, were encouraged to provide feedback about the service they received. People were able to raise concerns and the registered manager investigated complaints and learnt from complaints to make improvements. The registered manager worked positively with external professionals.

Summary of findings

The registered manager did not have effective systems and processes in place to ensure people received a high quality of care and people's needs were being met.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires improvement 

The service was not always safe.

People were not always protected from risks associated with their care and

documentation relating to their care did not reflect people's individual needs.

People's medicines were not effectively managed. Medicines were not stored safely and documentation relating to medicines was inaccurate.

People were not always protected from abuse and avoidable harm, because systems and processes were not in place to investigate allegations or evidence of abuse.

People lived in an environment which was clean and free from odour; however, staff were not always aware of infection control practices.

People told us they felt safe.

There were enough staff to meet people's needs.

Safe recruitment practices were in place.

Is the service effective?

Requires improvement 

The service was not always effective.

People's changing care needs were not always referred to relevant health

services in a timely manner.

People liked the meals provided but were not always supported to eat and drink enough and maintain a balanced diet.

People were not protected by the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as the registered manager and staff had limited knowledge of the legislative framework.

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

Is the service caring?

Requires improvement 

Aspects of the service were not caring.

Some people told us staff were caring but others told us there were times when staff were not caring towards them.

Staff did not always speak with people in a respectful manner.

People's confidentiality, privacy and dignity were not always respected.

People's end of life wishes were not understood by staff.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive.

People were not involved in the design and implementation of their own care plans which meant care planning documentation was not reflective of their wishes.

People's care plans were not individualised and did not provide guidance and direction to staff about how to meet people's care needs.

People's independence and social life were not promoted, which meant people had very little to occupy their time.

People could raise concerns/complaints and they were resolved to their satisfaction.

Is the service well-led?

Requires improvement 

Aspects of the service were not well led.

People did not receive a high standard of quality care because the provider's systems and processes for quality monitoring were ineffective in ensuring people's needs were met.

People and staff were encouraged to provide feedback about the running of the service.

There was a management structure in place and staff told us they felt well supported by the registered manager.

Higher Park Lodge

Detailed findings

Background to this inspection

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

We visited the home unannounced on 27 and 29 May 2015. The inspection team consisted of two inspectors and an expert by experience – this is a person who has personal experience of using or caring for someone who uses this type of service.

During our inspection, we spoke with 12 people living at the home, two relatives, one visitor, five members of care staff, one laundry assistant, one cleaner, two chefs, one activities coordinator, the deputy manager, and the registered manager. We carried out a Short Observational Framework Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed how people spent their afternoon in the lounge and watched how staff interacted with people during this time.

We observed care and support in communal areas, spoke with people in private and looked at nine care plans and associated care documentation. We also looked at records that related to medicines as well as documentation relating to the management of the service. These included policies and procedures, staffing rotas, the accident book, three staff recruitment files, training records and quality assurance and monitoring paperwork.

Before our inspection we reviewed the information we held about the home and spoke with the local authority. We reviewed notifications of incidents that the provider had sent us since the last inspection and previous inspection reports. A notification is information about important events, which the service is required to send us by law. After the inspection we contacted eight health and social care professionals who supported people who lived at Higher Park Lodge to obtain their views. We spoke with a district nurse, a psychiatric nurse, a podiatrist, and made contact with five GPs.

Requires improvement

Is the service safe?

Our findings

People's risk assessments, that give guidance to staff about how to minimise associated risks which related to people's individual care needs, were not always in place. Where they were in place, they had not been updated and reviewed effectively.

One person living in the home had mental health needs. There was no risk assessment in place to give staff guidance and direction about how to support the person. It had been recorded in the daily records for another person that they had become angry with staff. Because there were no risk assessments in place about how to support this person during such times, it was not clear how this person's needs were being met consistently and safely met.

When a risk had been identified, the registered manager had not always taken action to minimise the risk. For example the care plan for a person who was at risk of recurring urine infections, showed the person needed prompting with drinks. The person's care plan did not give clear guidance and direction to staff about what to do. Fluid charts in the person's bedroom were to be completed by staff every two hours to record how much the person was drinking. However, there were gaps in the charts and we found this person did not have a drink available. The daily records showed staff had been concerned the person had another urine infection but the staff had not responded to this by ensuring the person had enough to drink.

People's waterlow risk assessments which were in place to reduce damage to people's skin were not descriptive of the care which was needed or provided. This meant it was not clear how associated risks were being minimised to help prevent skin damage. For two people, their risk assessments showed they were at risk of skin damage. However, these people did not have specialist mattresses in place. The registered manager told us one of the people did have a specialist mattress in place; however we found they did not. This meant the person could be at risk of developing unnecessary skin damage. A health professional told us, because of previous concerns about people's skin care they had been working with the staff to improve their knowledge. However, they told us they continued to have concerns about whether staff always put this into practice.

Staff explained how they minimised risks, but told us they had not seen any risk assessments relating to individuals in care records they had read. One member of staff told us they had been shown how to hoist people and bathe them in ways that minimised risks to people's safety. Another member of staff explained how risks were managed when a person went out on their own, and told us they "hoped" this was written in their care plan. The registered manager spoke knowledgably about people and about the difficulties they faced, but people's risk assessments did not demonstrate this.

People's falls had been recorded and information was used to identify themes and necessary action which may be required. One person had been falling regularly; in response to this a referral had been made to external professionals. Accidents were recorded, however when an accident occurred it had not always been documented in the accident book. One person had cut their finger and had also fallen on the same day but there was no record of this. Documenting accidents and incidents helps to update risk assessments and to find solutions to potential risks.

Risk assessments were not always reflective of people's individual needs. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from abuse and avoidable harm. Staff confirmed they had access to the relevant policy which helped ensure they followed the correct procedures and staff were able to tell us about what action they would take if they suspected abuse was taking place. However, we read in the records for one person that there had been an incident, and staff had failed to report it to the registered manager. As a consequence of this, it had not been reported to the local authority safeguarding team for investigation.

Effective systems and processes were not in place to immediately investigate allegations or evidence of abuse. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not effectively managed to ensure they received them safely. Prescribed medicines which included controlled drugs were not always stored and administered safely in line with current and relevant regulations and guidance. For example we found a box of paracetamol in one person's bedroom. The duty manager

Requires improvement

Is the service safe?

told us care staff must have forgotten to lock it away in the person's bedroom cabinet. However, after we had informed the deputy manager the box of paracetamol was not locked away. The person's bedroom was unlocked, which meant the person and other people could access the medicine and could be at risk of taking too many tablets and overdosing. The medicine trolley was locked but not always secured to the wall, which meant the trolley could be removed. The storage of some medicines was not adequate as it did not meet the legal requirements.

People's medicine administration records (MARs) were not always accurately completed, for example for one person there were gaps on their MARs but their medicine had been given.

The controlled drug register for one person did not match the stock which was held, for one person there were 20 tablets recorded in the register but 22 tablets in stock and the duty manager was unable to provide an explanation for this. The registered manager told us there were no regular stock checks of medicines.

People did not have care plans in place for prescribed skin creams so staff did not have guidance and direction about when and where to apply the cream. Prescribed creams were not always dated when opened which meant expiry dates were not being reviewed. People who required regular medicine such as pain relief or laxatives were not always being offered them and records did not show staff were asking people.

People did not always receive their medicine from staff who were competently trained. For example, staff signed people's MARs before the person had taken their medicine which is incorrect practice because the person may choose to refuse their medicine which would then make their records inaccurate. One person was not offered anything to drink whilst taking their medicine. The staff told us the person liked to chew their tablets without a drink and that the GP was aware of this. The registered manager confirmed the GP was aware but was disappointed staff had not offered a drink.

People who were able to self-administer their medicine had no risk assessments or care plans in place. This meant there were no formal monitoring systems in place to ensure people were taking their medicines safely.

The management of medicines was unsafe and ineffective. Documentation relating to medicine management was not being completed accurately. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People lived in an environment which was clean and free from odour, but people may be at risk of infection as commodes were not always being emptied. One member of staff was not aware of how to correctly support one person whose health care needs required specific infection control practices. The registered manager told us practice was being addressed with the staff team

People told us they felt safe living at Higher Park Lodge, their comments included, "I'm safe.....nobody is abusive or would bully me" and "Nobody would do me any harm". A relative told us, "Mum feels safe living here".

People had personal emergency evacuation plans (PEEPS) in place which meant, in an evacuation emergency services would know what level of care and support people may need.

People were protected by safe recruitment procedures as all staff were subject to necessary checks which determined that they were suitable to work with vulnerable people.

People were supported by sufficient numbers of staff. The registered manager explained she did not use a staffing dependency tool to calculate the required staffing, but did take into consideration people's care needs. One person told us, "Night care is good and good staff...very good. I wanted help last night and I did not have to wait more than six minutes." Staff told us they felt there were enough staff. However, health professionals who visited the home regularly told us staff were not always available to be present when they were proving care and treatment to people, because they were too busy.

Requires improvement

Is the service effective?

Our findings

People's mental capacity was not always being assessed which meant care being provided by staff may not always be in line with people's wishes. The legislative framework of the Mental Capacity Act 2005 was not always being followed.

People's care plans did not always contain guidance and directions for staff about how to support people when they did not have the capacity to make decisions. For example, we were told by the registered manager one person frequently liked to stay in bed for long periods of time, but they were encouraged by staff to get up. This person's care plan stated they had the capacity to make all of their decisions, so it was unclear why staff were making this decision for the person. Other people had sensor mats in place which alerted staff when the person stepped on them, and bed rails in situ. There was no evidence in people's care plans about whether they had consented to these or, if people lacked the mental capacity to make these decisions, whether these had been made in the person's best interest.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), designed to protect people's human rights, with the registered manager. They demonstrated a limited understanding and knowledge of the requirements of the legislation. Under the Mental Capacity Act 2005 (MCA) adults are deemed to have capacity unless there is reason to think that they do not. If there is reason to question an adult's capacity there is a set procedure to be followed to establish if they are able to make their own decisions about important matters, such as leaving the care home. This assessment must be properly carried out by a suitable professional and it must be properly recorded and applications for deprivation of liberty safeguards should be made. The mental capacity of people living with dementia, who were at risk if they left the home unescorted, had not been assessed. Neither had any assessments been carried out in relation to people being deprived of their liberty.

When a person did have the ability to make certain decisions staff did not always respect the person's own decision. For example, at lunch time a member of care staff asked one person if they would like more to drink, the person replied "no, I am alright thank you", the member of care staff persisted in asking the person to "pass their cup over" of which the person did not. The member of staff did not respect the person's decision and took the cup off the table and filled it up. Before leaving the table they requested of the person "drink that up for me please".

People's care plans did not demonstrate their involvement in their care, for example the outcome of care reviews were not incorporated into people's care plans and documentation was contradictory in respect of their mental capacity. For example, records had been signed by staff when it had been recorded the person had capacity to make their own decisions and it was not recorded that the person had requested staff do this on their behalf.

We looked at the training records for the staff team; records showed that not all staff had received training in the MCA and DoLS. Staff demonstrated a limited understanding of the principles underpinning the legislation. However, staff were able to give us examples of how they obtained people's consent prior to assisting people, for example, "I always ask are they happy to have a male carer", and say "do you mind if I do so-and-so?"

The legislative framework of the Mental Capacity Act (MCA) 2005 was not always being followed. People's consent was not always obtained in relation to the care and treatment provided to them. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could choose if they wanted to eat their meal in the dining room or elsewhere. The lunch time experience was disorganised and people were left waiting for an hour prior to being served their meal. During this time, no one was given an explanation or offered anything to eat or drink. One person described how they felt and told us, "sitting like a dummy and I hate that....they [the staff] say 'oh we've been busy'". The registered manager told us the staff had been running late because the medicines had taken longer than usual to administer on that day. We were also told staff were nervous of our presence which was affecting how they were working.

The first person was seated at a table at 12pm when lunch was to be served at 12.30pm. The first person received their food at 1pm. One person shouted out "what time is tea?" The meal was already plated and there were no choices offered or any discussion with the person about portion

Requires improvement

Is the service effective?

size and whether they wanted everything that had been served up on their plate. The chef told us they were knowledgeable about people's likes and dislikes, however, people's preferences were not recorded in their care plans.

People were not respectfully supported during lunch time and given individual time and consideration, for example, one member of staff was seen to support two people at the same time. The member of staff supported the person at their own pace, however, a spoonful was given to one person and then to another, the member of staff did not sit at the person's eye level but stood above them.

People who had specific care needs were not supported at lunch time, for example one person was visually impaired. No attempt was made to let the person know who else was sitting at the table. The person was not sat next to someone to interact with, but was positioned so they were turned away from the table. Another person who used a wheel chair was unable to sit in close to the table to eat their meal, the person commented, "I don't want to be different...it happens every day".

People told us they did not know what they were having for lunch; one comment included "we don't know what we are having half the time". The chef had asked people in the morning but because people were living with dementia they could not remember what they had chosen. Menus were not in place for people to prompt their memory of what they had chosen. People were not offered a choice of drink.

The chef told us people were given choices, and they were knowledgeable about people and knew what people's likes and dislikes were. The chef told us everyone liked ice cream; however, one person had been given ice cream at lunch time but had not eaten it. They told us they did not like ice cream. Documentation and people's care plans did not always record people's likes and dislikes and did not demonstrate how people were being supported to make decisions about their meals.

People said to us they liked the meals, one person told us, "not bad. . .you get fed up of eating the same things". One relative told us, "the food is fantastic".

People's weights were recorded to identify weight loss and to prompt necessary action. The registered manager explained when there were concerns people were weighed more regularly.

For one person, action had been taken and external health professionals had been involved. However, for others the recording of their weight was inconsistent and did not always show action had been taken when weight loss had been identified.

People did not always have independent access to get their own drinks if they wished to. On our arrival some people who were in their bedrooms did not have a jug of water/ juice. One person had called a member of staff to ask for a drink. The person was seen to drink the full cup of water, but had not been left with a jug or another cup. One person whose jug was empty told us it was not always filled up regularly. During the day staff were prompting people to drink, one commented included, "It's a hot day. Don't be afraid to ask for more squash". People who are living with dementia may not remember to ask for a drink and there were no drinks in communal areas for people to freely access.

People had access to health care services to receive ongoing health care support; however referrals to relevant health services when people's needs changed did not always happen quickly. We read in the daily notes for one person that there was a concern about whether they had a urine infection. Recorded in the notes it had stated action should be taken to investigate this further, however, no action had been taken. For another person, it was recorded in their daily notes that there were concerns about their legs, however, this had not been shared with the staff team and no action had been taken.

Documentation required to support people in relation to their nutrition was inaccurate leading to a risk that people's individual needs may not being met. There was not always an understanding from staff about the recognition of a person's changing health care needs and the necessary action which may be required. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who had received relevant training, and supervision. Supervision is an opportunity for staff to discuss their working practices with their line manager, as well as ongoing learning and development. Some staff told us they received supervision whilst others had not. The registered manager provided supervision to staff; however, we were unable to determine the frequency of this as the recording of supervision was fragmented.

Requires improvement

Is the service effective?

Staff received an induction, however, there were no systems in place to make sure staff had completed their induction and were competent. One member of staff told us, they were not aware of any record being kept of their induction but told us there was a list in the office of what was to be covered. The registered manager confirmed they were aware of the new care certificate and told us this would form part of the induction. The care certificate is a national induction tool which providers are required to implement, to help ensure staff work to the desired standards expected within the health and social care sector.

The registered manager's training matrix showed some staff had undertaken training applicable to their role, for example dementia, health and safety, fire and infection control. The training matrix showed there was forthcoming training arranged for staff who had not completed all of the training. One member of care staff who had worked at the home for a few months told us that since their induction they had not had any training and were using manual handling equipment without any training. The registered manager told us that future training courses had been booked and staff would be expected to attend.

Higher Park Lodge provided care and support for people who were living with dementia. People were not supported by staff who were all trained in dementia care and did not demonstrate the principles of dementia care. For example, some people were seen to walk around the care home and staff did not always engage with people. The registered manager told us that this was not how it always was and it was because the staff were nervous during our inspection. The registered manager told us they had sought advice about the design and decoration of Higher Park Lodge in respect of the principles of dementia care. However, the environment did not always follow the principles of dementia care, for example providing people with a stimulating environment with good signage and contrasting colours.

People did not receive care and support from staff who had the right knowledge, experience and skills to support people. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

Overall staff were kind and caring, but some staff showed more patience and compassion than others. On our first day of inspection, we observed how staff spent time with people. We saw a mixed approach by staff in the way they spoke and engaged with people. One member of staff encouraged one person to help by handing round the biscuit tin. This practice supported the person's independence. However, one person was told off by a member of staff for taking too many biscuits, by saying "it was only two each… how many biscuits do you have? Some other people might not get a biscuit now". We asked a member of staff about whether there was a reason for why this person could only have two biscuits and we were told there was no reason. The registered manager and deputy manager also confirmed people could have as many biscuits as they liked and expressed their disappointment to hear this had occurred.

One member of staff showed a person kindness by crouching down beside the person, holding their hand and giving the person time to explain their worries at their own pace. Following this we heard the person say, "Isn't she a lovely lady". One person had lost their teeth and the staff spoke with the person about this, and began looking for them in a discreet way.

People's comments about staff included, "Carers are kindly… the majority.....they are also friends", "very, very helpful....nothing is too much trouble" and "all in all it's not bad....bit disturbed by [other people]...shouting". One person told us, "It's not as good as it was…it needs to change – they had time for you...more than anything I want them to listen to what you say". Two relatives told us, "It's brilliant they look after him very well....they would never harm him...I trust them" and "If I am ready for a home I'd come here".

Health and social care professionals all told us they felt the staff were kind towards people and showed patience when dealing with challenging situations.

People's end of life wishes were not care planned. The registered manager told us about one person who was becoming increasing frail and the GP was called for on a regular basis. Although, the registered manager was knowledgeable about this person and had supported them for a long time, this person had no end of life care plan in place. This meant the person was at risk of not having their choices and wishes for the end of their life met because there was no written information for staff to follow.

People's end of life wishes were not always obtained and recorded. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's privacy was not always respected. Some people had locks on their bedroom doors whilst others did not. The registered manager explained people were asked before they moved in whether they wanted a lock. This was recorded in people's care plan, but had not been reviewed. We read in the daily records for one person that they had been walking in and out of other people's rooms and staff were to be aware of this. This meant it was unclear how people's privacy and security were maintained at all times. One person told us they had no lock on their bedroom door. They explained, "asked a lot because there is a lot of stealing....by other residents....I lock stuff in a suitcase or hide it in my wardrobe....[…]wanders in my room.....Managers not doing anything and don't give a reason why I can't have one". We spoke with the registered manager about this who told us a lock would be fitted. People's privacy when having a bath/shower or using the toilet was compromised because the locks on bathroom doors did not always work.

Staff knocked on people's doors prior to entering their room. Staff shared with us examples of how they promoted people's privacy and dignity. They explained they knocked before entering people's rooms, ensured curtains and doors were closed as necessary when providing personal care, and that people were kept covered with a towel during their wash and shower.

People were not always shown respect, for example for some people their care needs and personal information was displayed in their bedrooms and for one person it was on the front door to their bedroom. One person's family had made a complaint about this. This was not respectful and meant private, personal information could be read by others.

People's confidentiality was not always respected, for example the registered manager spoke with a relative in the dining room. The conversation was personal and could

Requires improvement

Is the service caring?

be overheard by others. Information about people's health care was being recorded in one book which meant if people wanted to access their records they would also be able to read about other people.

People were not always treated with respect and consideration. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to express how they felt about the running of the care home at weekly and monthly meetings which were held by the activities co-ordinator. These meetings gave people an opportunity to tell the registered manager about anything they would like to see improved.

People were encouraged to be involved in decisions about their care and treatment, for one person we saw they were actively involved about their health and wellbeing. However, documentation did not demonstrate how people were being supported when they did not have the mental capacity to make those decisions.

People's family and friends could visit at any time. One relative told us he was made to feel welcome by staff when they visited.

Requires improvement

Is the service responsive?

Our findings

People told us there was not enough to do. Comments included, "I want to take a stroll... would it be a lot to mention it?", "not enough to do" and "we are rather stuck in, there are no outings.....could we get a bus I would like to go out....can't go on my own....I wish they would take me out". One person told us, "I spoke to carers yesterday to see if we could get a coach....go to the pub...we are just stuck in here all the time".

People were complimentary of the activities coordinator, and told us "if she can do anything she will". The activities coordinator told us people had expressed their frustration about the lack of activities and opportunities to go out. The registered manager was also aware of this and told us the recent recruitment of the activities coordinator would help this and work was underway to make improvements. The registered manager shared some examples of activities people had participated in such as baking and walks in the park. For people who chose to stay in their rooms the activities coordinator visited them and spent time with them. The activities coordinator worked two days each week and in their absence staff were expected to participate in promoting activities. During our two days of inspection, people did not participate in any social activity. The registered manager told us this was because staff were nervous and concerned about taking people out because there was an inspection being undertaken.

People did not always have a care plan in place. People's care plans did not guide and direct staff to deliver consistent care to people. For one person who had mental health needs, there were no care plans in place to provide guidance and direction to staff about how to support them.

Information in care plans was not always accurate; one person with the support of staff used a stand aid. However, the person's care plan stated they used a hoist. People who had diabetic care needs did not have care plans in place to provide guidance to staff. One person chose not to follow the advice of their GP regarding their diabetic care needs and this was being respected by staff. However, there was no documentation in their care plan about this and there was no guidance for staff should this person become ill. We read in one person's daily records that they had been assisted with their catheter bag, however, from reading the person's care plan, it was not recorded that they had a catheter. One person had Parkinsons, but there were no care plans in place regarding this. Daily records for one person had shown they had become angry with staff; this person had no care plans in place regarding the behaviour which they may exhibit, or how staff should respond to support the person in the way they wanted and needed.

People had not been involved in planning their own care to ensure they received the care they needed, in the way they wanted it provided. People's care plans had not been reviewed with people or their families. The registered manager told us people had an annual review, however, the review and outcome of the review was not reflected in people's care plans.

People's dementia care needs were not care planned, so it was unclear how people's individual needs were being supported by staff. People's care plans did not always include a personal history so staff were not aware of what a person achieved in life prior to getting older and moving into Higher Park Lodge. A person's history helps enable staff to have meaningful conversations with people and tailor social activities to people's past interests and memories.

Information relating to people's health was not always recorded in their care plan, but recorded in a daily communications book. This meant people's care plans were not reflective of their current health care needs and information was not always shared. For example, there was confusion about where one person's blood results had been recorded, we found the information had been recorded in a separate book and not in the person's care plan.

Important health care information about people was not always recorded. For example, on the first day of our inspection one person had told a member of staff they had not been feeling very well. When we returned on our second day this had not been recorded in the person's daily records so it was not clear if any action had been taken. On our second day the same person told us they were not feeling very well. We spoke with the deputy manager who told us the person sometimes said this frequently, but they would speak with the person to make sure everything was alright. One person's professional records had stated they were allergic to a particular medicine, however, the person's care plan and important information had not been updated to reflect this.

Requires improvement

Is the service responsive?

People's skin was not effectively monitored as records were not in place when people had problems with their skin. For example one person had a bruise to their eye. This had been recorded in their daily notes, but there was no body chart in place showing the exact location of the bruise. Another person was receiving treatment from district nurses for a sore on their heel however, there were no body charts in place to record this detail. Body charts help to monitor a person's skin, and can be useful in making sure timely referrals are made to health professionals.

The registered manager explained care plans were being reviewed and developed into a new format and we were shown one which had been completed.

Care plans were not always in place and did not reflect the care being delivered. The care being delivered by staff was not always consistent. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A social care professional was complimentary about the way in which the staff team had supported one of the people living at the home. We were told the staff encouraged and empowered the person to regain their confidence.

People's complaints were listened to, recorded and responded to. There was a complaints procedure and it was displayed for people and visitors. It was however, displayed high up on the wall which was difficult to see and was not in a format that may be suitable for people who live with dementia to understand. There was a suggestions box in the entrance of the home; the box was underneath a table and not easy to see. The registered manager explained that it was sometimes moved and this would be rectified.

Requires improvement

Is the service well-led?

Our findings

People did not receive a high standard of quality care because the provider did not have systems and processes in place to help ensure the service met regulations in respect of the planning of people's care, meeting people's individual needs, the management of medicines and the implementation of the legislative framework the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS). The registered manager was in the process of introducing a quality assurance system which would help to highlight areas which required improvement and would facilitate action.

The registered manager had a vison statement/policy in place called "our purpose". The policy emphasised people who lived at Higher Park Lodge should be provided with "the highest consistent standards of care…where their confidentiality, independence, privacy and dignity are respected and upheld". Our inspection findings showed the registered manager's vison for the service was not always being implemented by the staff team.

The registered manager explained one member of staff was responsible for ensuring fluid charts were completed on a daily basis and spot checks by the registered and deputy managers ensured this was happening. However, we found fluid charts to have gaps which meant the checks which were in place were not robust.

The systems in place to monitor the quality of service people received were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not notified the Commission of all significant events which had occurred in line with their legal obligations. For example, we read in one person's records that they had been admitted to hospital with a fracture. The Commission had not been made aware of this.

The registered manager had not always notified the Commission of all significant events. This is a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

People were able to speak with the registered manager or deputy manager at any time and during our inspection they both made themselves available to people at all times. One person told us, "there are two good managers they help out as much as they can".

There was a clear management structure in place which included the registered manager and deputy manager. There was no manager on duty at the weekends, but an on call system provided staff with support if required. The registered manager told us she attended the training which was organised for care staff to keep up to date with current practices. Although, the registered manager and deputy manager were present during our inspection, it was evident from our inspection findings that the registered manager of the service did not keep the day to day culture, including the attitude, values and behaviour of staff under review.

Staff told us they felt supported by the managers, comments included, "They're really good… they've always got their door open". We were told the management were always on call and popped in or rang in to check staff were managing and "helping with any problem, little or large". Staff were positive about staff meetings and said they were two way exchanges of information between management and staff. Staff felt free to give their views at the meetings, one member of staff told us "It's a supportive environment. You can speak as you find."

There was a whistle blowing policy in place to protect staff, and staff told us they would not hesitate to report any concerns to the registered manager or deputy manager.

People's views were obtained by an annual quality survey, this also included feedback from relatives, external professionals and staff. The registered manager was looking at new ways to share the results of the survey with people.

The registered manager and staff worked positively with external professionals and had been working in collaboration with the local authority safeguarding team in response to the concerns which had been raised. One external social care professional told us they felt the staff and registered manager were open to ideas and suggestions. They described the registered manager and deputy manager as approachable, kind and caring and felt the home was run professionally.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Person-centred care Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care plans, including for end of life care, were not always in place and did not always reflect the care being delivered. The care being delivered by staff was not always consistent. Documentation required to support people in relation to their nutrition was inaccurate leading to people's individual needs not being met. There was not always an understanding from staff about the recognition of a person's changing health care needs and the necessary action which may be required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Dignity and respect Regulation 10 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always treated with respect and consideration, and their privacy was not always maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Need for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The legislative framework of the Mental Capacity Act 2005 was not always being followed. People's consent was not always obtained in relation to the care and treatment provided to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment Regulation 12 (1) (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risk assessments were not always reflective of people's individual needs. The management of medicines was unsafe and ineffective. Documentation relating to medicine management was not being completed accurately.

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 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Effective systems and processes were not in place to immediately investigate allegations or evidence of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Good governance Regulation 17(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The systems in place to monitor the quality of service people received were not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not receive care and support from staff who had the right knowledge, experience and skills to support people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered manager had not always notified the Commission of all significant events.