RYSA Highfield Manor Limited

Highfield Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 19 and 20 April 2016 was unannounced. This focused inspection was carried out to review the progress on meeting the regulations and shortfalls identified at previous inspections .

We last inspected Highfield Manor Care Home in Jan 2016 and we identified repeated shortfalls and breaches of the regulations. The home received an overall rating of Inadequate at that and the July 2015 inspection. Whilst there had been some improvements found at this inspection we did not have evidence that these had been sustained or embedded to enable us to change the ratings given at the last comprehensive inspection.

Highfield Manor is registered to provide personal care for up to 46 people living with dementia. Nursing care is not provided. At the start of the inspection were 23 people living at the home at the time of the inspection. Three people moved out during the inspection.

There was not a registered manager at the home. The previous registered manager, who is also a director of the registered provider, cancelled their registration in August 2015. A management consultancy was appointed in January 2016 to oversee and manage the home until a new manager is appointed. Two of the management consultants were acting as interim 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.

At the comprehensive inspection in July 2015 this provider was placed into special measures by CQC. At the January 2016 inspection we found that there was not enough improvement in the service to take the provider out of special measures. This inspection was to review progress on the breaches of the regulations. The home remains in special measures.

In addition to placing the service in special measures in July 2015 we imposed an urgent condition on the provider's registration. This means further people cannot move into the home or return from hospital without our agreement. This was because people's care was not assessed, planned for and was not provided in a safe way. People's nutritional needs were not met and this placed them at risk of harm.

We have requested the provider send us an action plan every month to tell us what action they have taken to meet all of the shortfalls identified at the July 2015 and January 2016 inspections.

At this inspection we identified continued shortfalls and six repeated breaches of the regulations. The service had improved and met the regulations in relation to people's privacy and dignity and their nutrition. The complaint procedure was now displayed. The service's rating was displayed and we had been notified about incidents as required by the regulations.

CQC is now considering the appropriate regulatory response to the shortfalls we found. Where providers are not meeting the fundamental standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

There were some improvements in the risk management of individuals. However, some risks to people's safety were not consistently assessed and managed to minimise risks. For example, plans and the support were not in place to manage the risk for people who needed to be moved using equipment such as hoists and staff did not have access to the correct information about people and how to manage some risks.

People's medicines were not consistently safely managed or administered. This was because staff did not have clear instructions when they needed to give some people 'as needed' medicines. Some medicines plans and records did not include the correct information and this potentially placed people at risk of having medicines they no longer needed them or at the wrong time. The shortfalls in the people's risk and medicines management were a repeated breach of the regulations.

Some people's needs were not reassessed when their circumstances changed and care plans were not updated or did not include all the information staff needed to be able to care for people. Some care plans included contradictory information. Staff did not consistently follow care plans to deliver the care people needed. This meant people were at risk of not receiving the care they needed.

Staffing levels had been increased at night and there were plans to increase the staffing during the day. However, there were not consistently enough staff to meet some people's needs who were accommodated in the basement and the first floor particularly at mealtimes. This meant some people did not all receive the support they needed to eat at a dining table or at the same time as other people. Following the inspection the management consultants informed us the staffing had been increased. Most staff had not received the training they needed to be able to meet the needs of people living with dementia. These shortfalls were a repeated breach of the regulations.

Although some improvements had been made to the signage in the home, the building still was not suitable for people living with dementia and did not take into account national good practice such as that produced by the University of Stirling. There was a plan in place produced by the management consultants. However, because action had not been taken to fully address the suitability of the home since October 2014 this was a repeated breach of the regulations.

Staff still did not fully understand or adhere to the principles of the Mental Capacity Act 2005. This was because there were continued shortfalls in some staff's understanding and recording of people's consent, mental capacity assessments and decisions made in people's best interests. This was a repeated breach of the regulations.

The management consultants had made some improvements at the home. Relatives and staff told us they were open and approachable. However, there were still repeated shortfalls in the quality and safety of the service and any improvements had not been embedded to ensure the service met the regulations. The shortfalls in the governance of the home were a repeated breach of the regulations.

Some people were being deprived of their liberty and had Deprivation of Liberty Safeguards (DoLS) applications or authorisations in place. People's conditions in relation to their authorisations were being met. This was an improvement.

Some people's mealtime experiences were much improved from the last inspection. They were a social occasion for some people and staff supported people sensitively.

Some staff knew about people as individuals so they could provide personalised care. This was an improvement but this was not consistent across the staff team. Some people who were cared for in their bedrooms did have music playing but not all of these people had something to occupy or stimulate them that was based on their individual needs and preferences.

People were occupied during the inspection and actively engaged with staff. Staff were kind and responsive to people's needs. People and staff smiled and laughed with each other. They enjoyed doing activities together.

The management consultants were leading by example and provided guidance and support to staff so they could appropriately support people living with dementia.

Complaints information was now displayed and there was a system for investigating, managing and responding to complaints.

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

People were not consistently kept safe at the home.

Risks to people were not consistently managed to make sure they received the correct care they needed.

The management and administration of medicines was not consistently safe.

There were not always enough staff on duty at mealtimes on the lower basement and first floor.

Staff knew how to report any allegations of abuse.

Is the service effective?

Inadequate

People's needs were not always met effectively.

Staff needed further training to enable them to effectively meet people's assessed needs.

People's rights were not effectively protected because staff did not fully understand or adhere to the Mental Capacity Act 2005.

Some people's health care needs were not met to ensure that they kept well.

People were referred to specialist healthcare professionals when needed such as dieticians.

Is the service caring?

Requires Improvement

The service was caring.

People and their relatives told us staff were kind and caring.

Staff were fond of the people they were caring for.

Is the service responsive?

Inadequate

The service was not consistently responsive to people.

People did not always receive the care they needed, staff did not always follow care plans in place, people's care plans were not always updated and did not include all the information about their care and support needs. This meant staff did not have up to date information about how to care for people.

There were more activities and stimulation for people.

Complaints information was displayed

Is the service well-led?

Inadequate

The home was improving but was not yet well-led because the systems in place to monitor the quality of the service and drive forward improvements were not yet effective.

The culture at the home was improving but was still reactive rather than being in a position to be proactive in identifying and addressing shortfalls.

The rating for the service was now displayed so people and their visitors knew that the home was rated as Inadequate.

Highfield Manor Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 20 April 2016 and was unannounced. There were two inspectors in the inspection team who attended on both days.

We met and spoke with all 23 people living at Highfield Manor Care Home on the first day. Because some people were living with dementia we used 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 spoke with four visiting relatives. We also spoke with three management consultants and seven staff.

We looked at three people's care and support records and care monitoring records in detail, at monitoring records and specific elements of eleven other people's care plans. We looked at 21 people's medication administration records and documents about how the service was managed. These included one staff recruitment file and the staff training overview record, audits, meeting minutes, maintenance records and quality assurance records.

Before our inspection, we reviewed all the information we held about the service. This included the information about incidents the provider had notified us of, the provider's monthly action plans and safeguarding meeting minutes.

We did not contact any commissioners because the majority of people living at the home funded their own care. We contacted the local authority safeguarding team for an update on outstanding safeguarding allegation investigations.

Following the inspection, management consultants sent us information about staff recruitment, staff training and staffing levels.

Inadequate

Is the service safe?

Our findings

Because most people were living with dementia they were unable to tell us whether they felt safe. We observed people responding positively with smiles when staff approached them. This showed people felt relaxed with staff. Three people who were able to told us they felt safe at the home. One person told us on the first day of inspection they were very frightened following an incident with a staff member. They were more settled and had been reassured by one of the management consultant's actions on the second day of inspection. Relatives told us they felt their family members were safe at the home.

At our inspections in July 2015 and January 2016 we raised safeguarding alerts for some individuals and in July 2015 for the whole of the home because of the serious shortfalls we identified. The shortfalls in protecting people from abuse and improper treatment and the lack of effective systems and processes for investigating and reporting allegations of abuse were a repeated breach of the regulations.

At this inspection the management consultants had identified allegations of abuse and had reported them to the local authority safeguarding team as required. Following discussion with us during the inspection appropriate action was taken to safeguard people whilst these investigations were ongoing. An investigation into an outstanding allegation of abuse was also in progress by the management consultants. However, all of the actions identified at the safeguarding meetings in December 2015 and in March 2016 with the local authority were not yet fully met. This included providing specific training to all staff in relation to pain management and end of life care to nine of the staff. The management consultants told us in their training plan that this training would be completed by June 2016.

Following the inspection we were contacted by a relative of a person who had moved out the home. They raised concerns about some of the care their family member had received. This included concerns about their medicines administration, their skin damage, their family member's weight loss and lack of support to eat whilst at the home. We made a safeguarding referral to the local authority safeguarding team about these concerns. These allegations were investigated and substantiated by the local authority. The management consultants took action in response to the local authority's findings.

Information about safeguarding adults from abuse and how to report allegations was displayed in communal areas. The training records showed that not all staff had been trained in recognising and reporting allegations of abuse. The management consultants training plan identified that this training would be provided to all staff in June 2016.

At our inspections in July 2015 and January 2016 we found shortfalls in the risk management of people, medicines management, ensuring the premises are safe and ensuring that staff had the competence, skills, qualification and experience to safely provide care to people. These shortfalls were a repeated breach of the regulations.

At this inspection we looked at the medicines management systems in place at the home. Medicines were stored safely and there were systems in place for storing medicines that needed refrigeration. However, the

new medicines store room was over 25 degrees Celsius in the afternoon. This meant that some medicines may have been at risk of damage due to the temperature in the room.

We checked the medicine storage and stock management systems in place. We checked the stock for some specialist medicines and found the stock and the medicine record book balanced for those medicines. These specialist medicines had been audited the first day of the inspection by the interim manager and this was clearly recorded in the register.

At our inspections in July 2015 and January 2016 we identified that some people were prescribed PRN 'as needed' medicines such as sedative medicines to be used when they were upset or unsettled. They were to be used when staff had not been able to reassure the people as directed in their care plans. We had found that for some people these PRN sedative medicines had been used routinely.

At this inspection people's medicines had been reviewed and PRN sedative medicines were not routinely used. However, for one person their medicines plan and PRN plan made reference to the use of a sedative medicine. This person no longer needed this sedative medicine because they no longer became distressed and upset. The medicines had not been given or needed since August 2015 but this had not been reviewed and changed. This placed the person at risk of receiving these medicines when they no longer needed them.

We reviewed the PRN as needed plans in place for people. These plans had been written since the last inspection. However, they did not include clear instructions as to when they should be administered and one plan included incorrect reasons as to why the medicine should be administered.

Where PRN as needed medicines had been administered the reason for administration was not recorded. This meant there was not any record of the why these medicines had been administered to people.

One person, who was not living with dementia, told us they had been given a new tablet at the wrong time of day and that they had "stomach ache and a racing heart all day." We reviewed this person's medicines records and saw that the medicine had been administered at the wrong time due to the medicines record being printed incorrectly.

There were some improvements in the risk management of individuals. For example, one person who needed three staff to reposition them was supported by three staff and records demonstrated this had happened at other times as well. Another person's risk management plan had been updated to so staff had clear instructions as to how they could safely move the person from a bean bag. Where people had bed rails in use the risks had been assessed and planned for to minimise the risks of them climbing over them or becoming trapped.

There were some risks to people that had not been assessed or planned for. For example, we saw and staff told us one person was being hoisted following deterioration in their mobility. However, their moving and repositioning risk assessment and plan included they were walking with staff support.

People's care plans were kept in the main office and were not easily accessible to staff. We were told following the inspection this was to protect people's confidentiality. However, some staff told us they had not read people's care plans kept in the office. Staff had access to a different care file for each person. These were the files they used on a daily basis and they did not include all of the detailed information that the care plans kept in the office did. The care files used on a daily basis included a one page profile with important information including the person's medical history, their wishes in relation to resuscitation and a summary of their personal and social history. Two people's care files that staff had access to included incorrect

information about their wishes in relation to resuscitation. One of these also included out of date information about the person. This placed these people at risk of receiving medical treatment that differed to the recorded decisions in their care plans.

A third person's care file that staff recorded in did not include a one page profile so staff knew important information about them. This placed them at risk because the staff would not have had access to basic information about the person in an emergency. We identified these risks to the management consultants who took immediate action to update the information for these three people.

We observed the management consultants modelling positive person centred approaches with people. They guided staff and we saw some staff then followed this approach with people. However, 16 of the staff had not received dementia care training to make sure they had all the skills and knowledge to be able to fully meet people's needs. This was first identified in July 2015. The training plan sent us following the inspection showed this was planned for May 2016.

These shortfalls in the risks to people, medicines management, and ensuring that staff had the competence, skills, qualification and experience to safely provide care to people were repeated breaches of Regulation 12 (2) (a) (b) (c) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspections in July 2015 and January 2016 we found there were not enough staff to meet people's needs and this was a repeated breach of the regulations.

One person and two relatives told us they had noticed the increase in staffing over the last week.

At this inspection the management consultants had identified the week before the inspection there were not enough staff to meet people's needs. They increased the night staff by one member of staff and planned to increase the number of staff on duty during the day by one. This was following a re-assessment of people's dependency needs. We reviewed staff meeting minutes from February 2016 and staff rotas and saw that staff had identified more staff were needed. However, this meant the staffing shortfalls identified at the January 2016 inspection was not acted on until the week before the inspection in April 2016.

There were not consistently enough staff at mealtimes to support people to eat at the same time on the lower basement and first floor. This was because the 23 people were accommodated over three different living areas. The management consultants had identified this and had consulted with people and their relatives about moving people so they were accommodated on two floors. In addition they also planned to increase the staffing by one member of staff. We have not been able to assess whether this increase in staffing is sufficient to meet people's needs and the shortfalls in staffing levels at mealtimes identified at the inspection.

Some staff were still working excessive hours at the home over 50 hours a week and mostly worked 12 hour shifts. The management consultants told us most staff had now signed 48 hour working week opt out declaration. They told us they were waiting for newly appointed staff to start work and they anticipated the hours that staff were working would reduce.

The ongoing staffing shortfalls were a repeated breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in July 2015 we found some areas of the home to be very hot. We identified this as an area for improvement because the provider gave us assurances they had purchased air conditioning units. The

air conditioning units had not been purchased by the January 2016 inspection.

The monthly action plan for April 2016 provided to us by the management consultants identified that the providers will need to purchase air conditioning units to maintain the building at comfortable temperature. Making suitable arrangements for safely cooling the home remains as an area for improvement.

Inadequate

Is the service effective?

Our findings

At our inspections in July 2015 and January 2016 we identified people were not supported to eat and drink as directed by in their safe swallow plans written by their speech and language therapists (SALT). People's foods and fluids were not monitored and food and fluids were not available in the lower basement and first floor lounges. This was a repeated breach of the regulations.

Some people's mealtime experiences were mixed. This was because people living on the lower basement and first floor were not offered the opportunity to sit at a dining table and there were some delays for some people having their meals at the same time as everyone else because of the lack of staff to support people to eat and drink.

At this inspection we observed staff supporting to eat and drink in a sensitive and relaxed way. Staff chatted with people and explained to them what they were eating. People were offered choices of food and drinks in a way that they could understand if they were living with dementia. People who needed specialist diets such as soft foods or thickened fluids had these provided.

Staff had an understanding of people's food preferences and likes and dislikes. One person who was living with dementia liked jelly sweets and staff offered these to the person throughout the day. Person reacted by saying "more" and smiled until they had enough.

People's weights were being monitored and reviewed on a weekly or monthly basis dependent on risk. Most people's weight was stable or they had put on weight. Some people had lost weight and referrals were made to the GP and dietician for advice. People who were identified as nutritionally at risk were having their foods fortified (such as full fat cream, full fat milk, or full fat cheese added to their meals) to increase their weight and their food intake monitored.

There was an improvement in the overall monitoring of people's food and fluid intake. Where people's fluid intake fell below the recommended amount there was a written prompt to increase the person's fluid intake the next day. However, there were some days where the amounts of fluids people were having were not totalled. This was an area for improvement.

Photographs of the main meal of the day were displayed in each lounge area so people knew what was for lunch.

Snacks of cakes, fruit and sandwiches were available on each floor in small Perspex covered trays. Staff offered these to people throughout the inspection.

Coloured crockery was used throughout the home. This was good practice and research has shown that people living with dementia can see food more easily on coloured crockery and may subsequently eat more. Some people preferred to use china crockery and this choice was respected.

At our inspections in July 2015 and January 2016 we identified shortfalls in people's pain assessment, dental care and management and people's pressure area care management.

At this inspection most people's day to day health needs were met. We saw examples of where people had been referred to the GP, district nurses, community mental health teams and dieticians. However, some people's healthcare needs were still not effectively met.

For people we had previously identified shortfalls for in relation to seeing a dentist action had been taken, however, this was not consistent for everyone. For example, one person had not seen a dentist since July 2014.

We saw most people who were living with dementia were prescribed PRN 'as needed' pain relief had their pain assessed daily. However, some people who had pain from other health conditions did not routinely have their pain assessed using a recognised pain assessment tool. These tools are used to assess people's pain levels if they cannot verbalise if they are in pain. People living with dementia may not always be able to say or show when they are in pain. For example, one person who was living with dementia was visibly in pain with their contracted arm and called out when it was moved. Two different staff working with the person told us the person was in pain. The person was prescribed paracetamol three times a day but their pain had not been assessed to determine whether this pain relief was sufficient. Because this pain had not been assessed appropriate medical advice had not been sought to manage this person's pain.

The management consultants told us no one was being treated by the district nurses for any pressure ulcers. Records showed and staff told us people were being repositioned as detailed in their care plans to minimise the risk of pressure damage to their skin. There were monitoring systems in place to make sure peoples' specialist mattresses were working properly. This was an improvement.

Overall, people's feet were not pressing on the base of their beds and they had a pillow in place to cushion their feet. However, whilst one person was being supported to eat in bed their feet were pressing against the base of the bed. On that occasion there was not anything placed between their feet and the bed base to protect their feet from pressure areas. This placed them at risk of developing pressure areas on their feet because they were not able to reposition themselves.

The shortfalls in accurately assessing, planning and meeting people's care needs were a repeated breach of Regulation 9(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A private chiropodist visited the home on a six weekly basis and provided foot care to all of the people living at the home. Records were kept about the treatment provided. However, we saw from records that they would no longer be providing the service to the home. The management consultants had identified they needed to appoint a new chiropodist.

At our inspections in July 2015 and January 2016 we found the service was not fully meeting the requirements of the Mental Capacity Act 2005. This was because staff still did not fully understand or adhere to the principles of the Mental Capacity act 2005. This was a repeated breach of the regulations.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed.

15 of the 24 staff have received Mental Capacity Act and Deprivation of Liberty Safeguards training. At this

inspection staff sought people's consent before they supported them. Staff had an understanding of how they needed to seek each person's consent. Relatives told us their consent was sought for specific decisions where their family member was living with dementia and they had a specific lasting power of attorney.

Some people had mental capacity to make their own decisions. However, consent records had been signed by a relative rather than the individual. This was identified at the inspection in January 2016 and had not been actioned.

Where people lacked mental capacity to make a specific decision, in general, mental capacity assessments had been completed. However, there were still shortfalls in completing mental capacity assessments and making specific best interest decisions. For example, one person had a lap belt on their wheelchair and this could be perceived as form of restraint to prevent the person standing up. However, this decision had not been considered under the MCA and whether it was in the person's best interests. The use of the lap belt was not included in the person care records. For a second person their consent records were signed by a relative but there was not any record of whether the relative had the legal authority such as a power of attorney to do this. For a third person there were records of mental capacity assessments in relation to their consent to medicines, care and treatment and living at the home. However, there were not any subsequent best interest decisions recorded about these specific areas.

These shortfalls of acting in accordance with the Mental Capacity Act 2005 were a repeated breach of Regulation 11 (1) (2) (3) (4) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in January 2016 some people were being deprived of their liberty and had Deprivation of Liberty Safeguards (DoLS) applications or authorisations in place. Some people's conditions in relation to their authorisations were not being met and one person was being deprived of their liberty unlawfully. This was new breach of the regulations.

At this inspection there was a system in place to monitor people's Deprivation of Liberty Safeguards (DoLS) applications and authorisations. People who were subject to an application or authorisation who died were referred to the coroner as required. This was an improvement.

The management consultants and staff were aware of people's DoLS conditions and at the time of the inspection these were being met. This was an improvement. However, information shared with us before the inspection from the safeguarding team identified that when they visited the home on 7 April 2016 the conditions for one person were not being met. The safeguarding team fed this back to the management consultants who then took action to ensure the person's conditions were met.

At our inspections in October 2014, March 2015, July 2015 and January 2016 we identified the premises were not suitable for people living with dementia and did not take into account national good practice such as that produced by the University of Stirling's Dementia Service Development Centre (DSDC). We reported at all inspections that improvements could be made with respect to signage in the home so people could identify and recognise toilets, bathrooms and bedrooms. This was a breach of the regulations.

At this inspection people's bedrooms and bathrooms and toilets had signage. People had chosen photographs and pictures of things that were important to them. This helped people to recognise their bedrooms. Coloured toilet seats had been fitted and the contrasting colour helped people living with dementia to clearly see and recognise the toilets.
The environment and decor was not suitable for people living with dementia. This was because the colours were neutral and there were not any contrasting colour differences between handrails, doors, walls and

furniture. People living with dementia and with sight loss cannot distinguish doorways and floors etc. when there are not any contrasting colours. This can have an impact of people's independence and their ability to move around the home independently. Although there was some signage on doors of rooms there was not any signage or cues to lead people to the outdoors, bathrooms and toilets or to different areas of the home and to encourage people to walk around the home and outside spaces.
The management consultants had developed a dementia environment plan. This plan included developing themed areas to provide interest and stimulation to people. In addition redecorating and material changes to some of the living areas had been identified. As the works had not been completed the shortfalls in the suitability the building were a continuing breach of Regulation 15 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At previous inspections we identified shortfalls in the supervision, appraisals and training of the staff team. We identified this as an area for improvement.

At this inspection staff told us things had improved at the home and they felt well supported by the management consultants. Staff that had been employed for over a year had not yet appraisals and the management consultants had identified that these needed to be completed. This was so they could understand the staff team's training and development needs.

The management consultants sent us a summary of the staff training completed and their training plan. Staff had not yet received all the training identified at previous inspections to make sure they had the skills and knowledge to meet people's needs. The new training plan included; dementia, moving and handling, safeguarding adults, medication, first aid, Infection control, MCA and DoLS, pain management and end of life care training. The training plan showed that this training would be delivered by the end of June 2016.

We identified from observations and care records that some staff needed further guidance and training in relation to treating people with respect and acknowledging that they worked in people's home. Not all of the staff who administered medicines had their competency assessed to make sure they were competent to administer medicines.

The shortfalls in staff training were a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Two people and relatives spoke highly of the staff and said they were kind and caring. One person said, "I'm very happy here I have no complaints and the carers are great". Another person said, "Staff are terrific". Following our last inspection we received two letters from relatives in these letters they commented on the caring qualities of staff.

At our inspections in July 2015 and January 2016 people were not treated with respect, their dignity was not maintained and their independence was not promoted. This was a breach of the regulations.

At this inspection overall staff were observed to treat people with dignity and respect. They spoke with people kindly and they were patient with people.

Some people were prompted and supported to be independent in some areas of their lives such as eating and drinking. Their meal time was a very socialable occasion with staff chatting with these people about their lives, their likes and dislikes. We saw one person in the ground floor lounge helping staff to fold some towels.

We did observe one staff member who did not respect that they worked in the peoples' home and they raised their voice. In addition some of the care and handover records about one person were not respectful. We fed this back to the management consultants and identified this as an area for improvement.

Inadequate

Is the service responsive?

Our findings

At our inspections in July 2015 and January 2016 we found some people were not receiving the support they needed to meet their care and emotional well-being needs. In addition, people's needs had not been assessed and care plans had not been put in place or they had not been followed. This was a repeated breach of the regulations.

Some people's needs had been reassessed since the last inspection and some new care plans had been developed. We saw some people's care plans had been audited but all of the shortfalls identified had not been addressed. Overall the care plans were personalised and gave staff clear direction as to how to care and support people. However, some people's care plans were not consistently followed by staff and did not include all of the areas of a person's needs. This meant staff did not have all of the information they needed to be able to provide the right care and support to people.

Two people who had contracted hands did not have their palm protectors on both days of the inspection. These had been provided an occupational therapist. Staff said that one person did not have their palm protector on because they had a bruise on their hand and they had been instructed not to put it on by the deputy manager. This person's skin on their hand was discoloured but did not appear bruised. Their finger nails were long and at risk of digging in their palm because of the contraction of their hand. We reviewed this person's records and saw they had not had their palm protector on for five days and there had not been any review of this. In addition the instructions in the care plan were not clear. This meant staff did not have clear information as how to care the person's hand and what was the maximum amount of time to leave the palm protector off.

We reviewed the other person's care plan and information about their palm protector and instructions from the occupational therapist had been put in a care plan as identified at the last inspection. The occupational therapist had left written instructions that the person's hand needed washing daily and staff needed to monitor the thumb web space. Staff told us that they were not sure why this person was not using their palm protector and they thought that the person had put the palm protector down the toilet. This person's care needs had not been planned for and delivered. This placed them at risk of further damage to their contracted hand.

In addition the some people's care plans included incorrect information and directions for staff. This placed people at risk of receiving the incorrect care and support. For example, one person's care plan detailed that they displayed certain behaviours that required a positive response from staff and the use of a sedative medicine. Staff, observations and records told us this person no longer behaved in this way and had not needed to have any sedative medicines since August 2015.

Another person was sat in a wheelchair in a hoist sling. The management consultants confirmed the sling was a breathable sling that the person could safely sit in it without causing skin damage. However, the person's care plan stated a different type of sling was in use and included instructions that the sling was to be removed whilst they were sat in the wheelchair. This incorrect information placed the person at risk of

receiving inappropriate care.

A third person's profile information made reference to them going outside for a cigarette and having evaporated milk in their tea and on cereal. We saw from records that the person's needs had changed to such an extent they were no longer able to leave the home without staff support to have a cigarette. The records did not show the person was taken out for a cigarette. A staff member told us this person had not had a cigarette in the eight months they had worked at the home. They said the person just had milk in their tea and cereal. We did not observe the person being offered evaporated milk in their drinks when they were given a hot drink. This meant this person's preferences and needs were not being met. In addition their care plan and personal profile had not been updated to reflect they no longer had a cigarette.

Some people's preferences about their personal care were not met. For example, one person's care plan included they preferred a shower. However, although they had a daily wash they had not had a shower for 10 days. Another person's recorded preferences were for a bath once a week and although they had a daily wash they had not had a bath for 20 days.

One person had a callous/sore on their foot that was clearly visible. This was not recorded in the person's care records or on a body map. There was not a care plan in place to instruct staff how to monitor the area and care for the person's feet. This was a particularly vulnerable area as the person had previously received district nursing care for injuries to their feet.

Some people's care plans and records included contradictory and confusing information about people's preferred names. This meant that staff used different names for people to the preferences recorded.

These shortfalls in people's needs being fully assessed, planned for and delivered were a repeated breach of Regulation 9 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection staff responded to people and their requests. They were quick to respond to and in some cases anticipated people's needs. For example, staff noticed when one person looked at a cup and they gave them a drink. Most staff responded quietly and quickly when people appeared unsettled or were looking for something to do. One person was supported to go for a walk down the road when they became unsettled.

There were things for people to pick up and do in the lounges. These ranged from books, magazines, adult colouring books, soft toys and tactile and brightly coloured objects. One person was unsettled and was looking for their baby, staff tried to reassure this person by giving them a soft toy to hold. However, the person was still unsettled. The management consultants told us they would be purchasing some therapy dolls which can benefit some people living with dementia. They hoped that a therapy doll would meet this person's needs.

There was a programme of activities each day and the activities worker spent time with people on an individual basis and in groups. During the inspection people who chose to were planting seeds for vegetables and flowers.

Some people who spent time in their bedrooms had music or the radio to listen to. However, other people who spent time in bed did not have anything they could see on their walls or things to hold and do to stimulate them whilst they were in bed.

In the main staff interactions with people were much improved at this inspection. Staff sang with people, sat

and chatted with them about their lives, engaged with them in activities and kept them occupied. People and staff smiled and laughed with each other.

Staff were knowledgeable about people's physical and personal care needs. At this inspection more of the care staff were able to tell us about the people as individuals, what and who was important to them and any of their personal history. Each person had a 'This is me' document completed. 'This is me' is a practical tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. It enables health and social care professionals to see the person as an individual and deliver person-centred care that is tailored specifically to the person's needs.

At our inspections in July 2015 and January 2016 we found the shortfalls in the complaints systems were a breach of the regulations. This was because the complaints procedure was not displayed and there was contradictory information in the complaints procedure and people's contracts.

Two people and relatives told us they did not have any concerns or complaints about the home. They were aware of how they could raise any concerns or complaints. They told us they had confidence in the management consultants and that they had acted on any concerns raised with them.

The complaints procedure had been re written and was displayed in the main reception area of the home. There had been no complaints received since the inspection in January 2016. However, the complaints procedure did not inform people they could complain to ombudsman if they were dissatisfied with the outcome of the home's complaint investigation. This was an area for improvement.

Inadequate

Is the service well-led?

Our findings

At our July 2015 and January 2016 inspections we found the home was not well-led. This was a repeated breach of the regulations.

During the January 2016 inspection the providers appointed a new management consultancy to support the home. The home has not had a registered manager since August 2015 when one of the directors of the provider cancelled their registration as manager. A new manager was appointed but we were informed following the inspection they had decided not to take up the post.

The providers entered into a management contract with the management consultants during the first week in April 2016. This meant the management consultants would be responsible for the day to day management of the home whilst the provider remained responsible for the finances, maintenance of equipment and the environment. The plan was for the management consultants to manage the home and then to have a planned handover to the new manager. Following this the management consultants would be providing operational oversight. They will continue to be responsible for the overall care provision at the home.

The director of the provider and management consultants had interviewed and appointed a new manager. This manager was due to start the week following the inspection, had been visiting the home and had been involved in the recruitment of new staff. We requested this person's recruitment file. There was evidence of the person's interview, identity, references and DBS checks. There was not any application form or evidence of the person's previous work history in their file as required by the regulations. The management consultants acknowledged the director of the provider had these documents and agreed to send them to us following the inspection. However, they later confirmed an application form had not been completed prior to interview and specific date information in relation to the person's work history had not be sought or explored. This meant there were not robust governance systems in place for recruiting staff.

Following our inspection in July 2015 because of the concerns we identified, we imposed a condition of registration. This was that further people cannot move into the home or return from hospital without our agreement. We were informed by the management consultants that this condition had been breached when a person was readmitted into the home from hospital without the agreement of CQC. This breach of the conditions of the services registration and is a serious matter. It is criminal offence under Section 33 Health and Social Care Act 2008 to fail to comply with a condition of registration and this may be subject to further enforcement action.

The management consultants have been providing us with a monthly action plan as required since the January 2016 inspection. However, the action plan for March 2016 did not include how the provider planned to meet the breaches of regulations identified in the January 2016 inspection report. We asked the provider and management consultants to provide a further action plan and this was provided. The different action plans gave some contradictory information as to whether improvements had been made and the regulations were met. For example, the April 2016 action plan identified that further work was required on

most of the shortfalls identified at the January 2016 inspection. However, we did identify that for some of the areas such as medicines management that had been identified in the action plan as meeting the regulations, that the monitoring and auditing systems had not been effective. This was because of the medicines shortfalls we found during the inspection.

We reviewed the surveys that the provider had sent to relatives following the January 2016 inspection. Most of them were positive. Four of the 10 surveys identified stimulation activities as an area for improvement. The provider had hand written an additional question that required a yes or no answer. The question was not an open question and the wording was biased so as to influence whoever was completing the survey. We discussed this with the management consultants who acknowledged this was not good practice.

Overall record keeping at the home had improved but as detailed earlier in the report some people's fluid monitoring records were not totalled.

People's personal information and the contact details for relatives were included in the comments and compliment book that was displayed on the front reception desk. We raised this with the management consultants who immediately removed it the documents from the reception.

Following the inspection we were contacted by a relative of someone who had moved out of the home. They raised concerns about the communication with home and the poor handover of information for their family member.

We received feedback from the local authority safeguarding team who visited the home in April 2016. They raised concerns that there were still shortfalls in the safety and quality of service provided to some people and that any improvements noted in their previous visits had not been fully implemented or sustained.

We reviewed the systems in place to assess, monitor and review the quality and safety of the service. Incidents, accidents and falls were being reviewed on a monthly basis. Care plans had been audited and daily staff handovers were recorded.

Actions identified in the home's improvement plan had not yet been completed to ensure the home was meeting the regulations. The findings throughout the inspection showed that although there were overall improvements in some people's experiences and the care they received, there was still a failure to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk. Although there were systems in place to assess and monitor the service these had yet to fully improve the quality and safety of the services provided.

The provider has not consistently achieved or sustained compliance with the regulations since October 2014.

These shortfalls in the governance and record keeping were a repeated breach of Regulation 17 (1)(2)(a)(b)(c)(d) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found shortfalls in making notifications to CQC. This was a breach of the regulations. Following the last inspection notifications had been made for most incidents that needed reporting. However, we were made aware by health and social care professionals about significant incidents relating to one person. We discussed these with the management consultants and clarified the need for CQC to be notified of these incidents.

At the inspection in January 2016 the CQC rating for the home was not displayed nor was there a copy of the inspection report available for people and visitors to see. This was a breach of the regulations. At this inspection the inspection report and rating was available on the main reception desk.

The management consultants told us they were moving away from the previous poor management culture of blame and different staff being treated differently. Staff told us and we also observed a changing culture in the home. Staff were encouraged and supported by the management consultants. They were leading by example in all of their interactions with people and staff spoke very highly of the newly developing culture. They spoke positively of the impact the increased staffing levels were having on people. Staff said they were listened to and things were acted on. One staff member told us they could "Feel the difference in a good way" and there was a big difference between the old and new management styles. They said, "They are respecting my rights and I'm now coming to work with a smile".

Relatives we spoke with during the inspection told us the management consultants were very visible and approachable. They told us about the previous weeks relatives meeting and they had felt involved and kept up to date with things at the home. They did comment they would have preferred more notice for the meetings and they thought then more relatives may have been able to attend.

The management consultants were open and transparent with us and acted immediately to respond to any shortfalls we identified. They have provided further information to us as requested and kept us updated about progress and incidents at the home.