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Highnam Hall

Inspection report

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Ratings

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

Overall summary

This inspection took place on 27 January 2015 and was unannounced. We last inspected the service on 18 October 2013. The home was meeting the regulations we inspected.

Highnam Hall is registered to provide residential care to 37 people some of whom are living with dementia. At the time of our inspection there were 31 people living at the home. The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the provider had breached Regulations 9, 12, 13 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Some people did not receive the care they required to maintain their wellbeing and ensure they were safe. This

Summary of findings

was because care had not been specifically planned and delivered to meet their individual needs. We saw that people were left unsupervised for long periods of time which meant staff were not always available to support people appropriately. Medicines were not always managed safely for people. Records relating to the administration and stock control of medicines had not been completed accurately placing people at risk of medicines errors. We also found the current audit systems in place at the home were ineffective in identifying gaps in medicines records.

The home did not have adequate emergency procedures in place. The exit route from the home in case of emergency was kept locked with a bolt. The route was also partially blocked potentially preventing people from leaving this area safely. Staff members said they did not know what individual assessments had taken place in relation to people's evacuation support needs. Staff also told us they were not aware of any fire wardens in the home and who was in charge in an emergency. The home's fire zone plan was out of date and did not reflect the changed usage of some rooms or the change in locations of the fire extinguishers. An action plan had been implemented, following an 'unsatisfactory' fire safety inspection, to improve fire safety in the home.

'Deep cleans' had not recently taken place which meant the home was not clean. For example, we saw that a rubbish bin in a bathroom was overflowing onto the floor, there was no soap or hand wash in the staff and visitor's toilet and a bath had not been cleaned after use. We observed items of clothing had been discarded and left around the home. We noticed a strong odour of urine in one area of the home which had not been dealt with in a timely manner.

People we spoke with told us they felt safe living at the home. One person said, "Yes I feel safe. Safe with the staff, I trust them. And safe in the house too, it seems to be very well looked after." Another person said, "I feel very safe here, nothing to worry about." Staff took care when supporting people to ensure they were protected from risks.

The provider undertook a range of standard assessments to help protect people from a range of potential risks including poor nutrition and moving and handling. Although care plans also identified potential risks. These were not specific and did not identify the controls needed to manage the risk.

Staff had a good understanding of safeguarding and knew about the provider's whistle blowing procedure. This included how to report their concerns. One member of care staff said, "Thankfully I've never had to use it [whistle blowing procedure] but I wouldn't hesitate, I know how important it is and who it's there to protect." Safeguarding concerns had been logged and investigated appropriately.

Staff told us they sometimes felt under pressure due to repeated sickness within the staff team. One staff member said, "Staffing is usually fine but some people are very unreliable and there is a high level of sickness." The registered manager had implemented an attendance improvement plan to try and address this problem. Staffing levels were analysed regularly to check there were enough staff to meet people's needs. As a result of this analysis the start times for the morning shift had been staggered to help staff provide the support people needed.

The provider had recruitment procedures to check new staff were suitable to care for and support vulnerable adults. This included requesting and receiving references and disclosure and barring service (DBS) checks.

Incidents and accidents were reviewed every three months. However, the review was not effective in identifying clear learning or directions for staff to try and reduce future accidents.

Records confirmed staff training was mostly up to date. We saw that staff were also receiving regular supervision and appraisal. New staff completed an induction programme with more experienced staff supervising them until they were able to work independently.

The provider was following the requirements of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards. We found that where required, DoLS applications had been submitted to the local authority for authorisation. The registered manager told us all people where there were doubts about their

Summary of findings

capacity had DoLS authorisations in place. Staff had a good understanding of their responsibilities under the MCA. Staff told us they had received training in the MCA and DoLS.

Staff told us, and records confirmed, that they had not completed training relating to behaviour that challenged the service. They said some people occasionally had "challenging or aggressive outbursts." One staff member said although they could use some de-escalation techniques to help reassure and calm the person, they had not been formally trained in this and so just had to, "do their best."

People gave us mixed views about the meals they were given. One person said, "It's okay I suppose. Breakfast is pretty routine. I like porridge but they never have anything to put in it so it's very plain." Another person said, "The food is delicious, I always look forward to mealtimes." We saw people did not always experience a pleasant dining experience. For example, we observed little interaction between people and staff, staff not being attentive and examples of people not receiving the support they needed as staff were busy.

People had regular input from a range of healthcare professionals including specialist nurses, community nurses, GPs, dentists, opticians, dietitians and speech and language therapists.

We found improvements were required to ensure the service was appropriate to meet the needs of people living with dementia. For example, the home did not have a dedicated 'dementia champion' and detailed life histories had not been developed. Most staff had not completed specific training in dementia awareness and meaningful activities specifically for people living with dementia were not available. We have made a recommendation about this.

People gave us positive feedback about their care. One person said, "It is nice here. The staff are lovely." Another person we spoke with said, "The staff work hard and are very kind. They're very patient and never rush you." We spent time observing people in communal areas of the home. We observed there was often a lack of staff in communal lounge areas which meant people were often not supervised and lacked attention from staff for long periods. We carried out an observation for 50 minutes in the downstairs communal lounge, using the Standard Observation Framework for Inspection (SOFI). We saw throughout the observation period the three people received little interaction from staff.

People had access to independent advice and assistance (advocacy) when they needed it. The registered manager confirmed most people living in the home had representation from either an independent advocate or a family member.

Staff had a good awareness of people's needs including their likes and dislikes. Care records included some personalised information about each person including details of their next of kin, health professionals and a brief history about the person. Care plans included information about people's personal hygiene needs, mobility and dietary intake. People had their needs assessed when they were admitted into the home and this information was used to develop care plans.

We heard mixed views about opportunities to take part in activities. One person said, "Not much goes on around here. Staff are nice but most of the time we just sit." Another person said they were, "Not aware of any activities." Another person said, "Sometimes it can be quite sociable. Especially at mealtimes people can get together and chat." On one occasion a person said, "I am bored stiff." Staff told us the lack of an activities coordinator had meant that activities were difficult to organise and plan.

There were opportunities for people, family members and visiting professionals to give their views about the care provided at the home. This included questionnaires and meetings with staff. We saw there was a system to log and investigate complaints. People did not raise any specific complaints with us during our inspection.

The home had a registered manager. People and staff said the home had a good atmosphere. One person said, "The staff are like my extended family, they're so lovely." The registered manager said staff could speak with her whenever they needed to. Staff also confirmed the manager was approachable. One staff member told us, "I know we're short staffed but we're here for the residents and nothing else. The manager supports us brilliantly and her door is always open or she's always on the end of the phone. I've never felt that there's a problem I can't approach her about."

Summary of findings

The registered manager told us they regularly observed staff member's care practice whilst walking around the home to ensure people were treated with dignity and respect. The quality of care plans was usually checked monthly and these checks were successful in identifying issues with care plans and ensuring action was taken. For example, checks had identified that one person required additional care plans to be developed. Other people needed particular documents signing to show their consent to receive care.

The registered manager undertook a six monthly quality audit. This included checks on supervision, health and safety, fire safety, care plan updates and staffing levels. The audit also included an analysis of complaints, safeguarding, accidents and incidents. The records showed that action was taken to prevent incidents happening in the future, such as changing staff shift times and raising awareness of issues at team meetings.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Medicines were not always managed safely for people because of inaccurate medicines records.

The home did not have adequate emergency procedures in place as there was a risk people would not be able to leave safely in an emergency. 'Deep cleans' had not recently taken place which meant the home was not clean.

People we spoke with told us they felt safe living at the home. The provider undertook standard assessments to help protect people from a range of potential risks. Staff had a good understanding of safeguarding and whistle blowing including how to report their concerns. Incidents and accidents were reviewed every three months.

Staff told us they sometimes felt under pressure due to repeated sickness within the staff team. An attendance improvement plan had been implemented. Staffing levels were analysed regularly to check there were enough staff to meet people's needs. The provider had recruitment procedures to check new staff were suitable to care for and support vulnerable adults.

Is the service effective?

Requires Improvement

The service was not always effective. Records confirmed staff training was mostly up to date. However, staff had not completed training relating to behaviour that challenged the service or dementia awareness. Staff were receiving regular supervision and appraisal.

The provider was following the requirements of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been submitted to the local authority for approval. Staff had a good understanding of their responsibilities under the MCA and had completed specific training.

People gave us mixed views about the meals they were given. We saw people did not always experience a pleasant dining experience as they did not always receive the support they needed. People had regular input from a range of healthcare professionals. Improvements were required to ensure the service was appropriate to meet the needs of people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring. Care was not always delivered to meet people's individual needs. We saw that people were left unsupervised for long periods of time which meant staff were not always available to care for them appropriately.

Summary of findings

People gave us positive feedback about their care. We spent time observing people in communal areas of the home. We saw throughout our observations people received little interaction from staff.

People had access to independent advice and assistance (advocacy) when they needed it.

Is the service responsive?

Inadequate

The service was not always responsive. Care had not been specifically planned to meet people's individual needs. People gave us mixed views about opportunities to take part in activities. Staff told us the lack of an activities coordinator had meant that activities were difficult to organise and plan.

Staff had a good awareness of people's needs including their likes and dislikes. Care records included some personalised information about each person including details of their next of kin, health professionals and a brief history about the person. People had their needs assessed when they were admitted into the home and this information was used to develop care plans.

There were opportunities for people, family members and visiting professionals to give their views about the care provided at the home. This included questionnaires and meetings with staff. People did not raise any specific complaints with us during our inspection.

Is the service well-led?

Requires Improvement

The service was not always well led. Medicines audit systems in place at the home were ineffective in identifying gaps in medicines records.

The home had a registered manager. People and staff said the home had a good atmosphere. The registered manager told us she regularly observed staff member's care practice whilst walking around the home to ensure people were treated with dignity and respect.

The quality of care plans was usually checked monthly. The registered manager undertook a six monthly quality audit. This included checks on supervision, health and safety, fire safety, care plan updates and staffing levels. People and family members were sent questionnaires as part of the on-going quality assurance programme.

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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 27 January 2015 and was unannounced. The inspection team consisted of two adult social care inspectors.

We reviewed information we held about the home, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also spoke with the local authority commissioners for the service.

We used the Short Observations Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with four people who used the service. We also spoke with the registered manager and three care staff. We observed how staff interacted with people and looked at a range of care records. These included care records for seven of the 31 people who used the service, ten people's medicines records, recruitment records for five staff and the home's emergency plans.

Inadequate

Is the service safe?

Our findings

Medicines were not handled safely because records were not completed correctly. This placed people at risk of medicines errors. We viewed the medicines administration records (MARs) for ten people who used the service. For seven people we found gaps in the MAR where staff had not signed to confirm medicines had been given or recorded a non-administration code where they hadn't been given. We cross-checked people's MARs with the relevant medicines stock control sheets. We found for all ten people the medicines stock control records did not match the entries on the person's MAR. For example, for one person the MAR showed that a particular medicine had been given on six occasions. However, the corresponding stock control sheet for the same medicine only had four entries recorded. Therefore, we could not be sure from viewing the medicines records whether people were having their medicines administered correctly. We discussed our finding with the registered manager who was unaware of these gaps in records.

We asked to view the guidance or protocols available to staff about 'when required' medicines. We found this was not available for some medicines. For example, some people had been prescribed specific medicines to help with supporting and managing behaviours that challenge the service. This meant there was a risk care workers did not have enough information about these medicines, to understand what they had been prescribed for and how to safely administer them. Appropriate arrangements for the safe storage of some medicines had not been made. We saw some medicines were stored in locked medicines trollies which were located in a communal area of the home. However, the trollies had not been attached to a wall or together for additional security.

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

The provider maintained accurate and up to date records for the receipt and disposal of medicines. The provider also had accurate records relating to the management of drugs liable to misuse (controlled drugs). One person who used the service was receiving their medicines covertly (without their knowledge). We saw that this decision had been made in line with the Mental Capacity Act 2005 in the person's 'best interests.' The provider had the required documentation in place for this decision, which had been made jointly with staff and the person's GP. We observed senior care staff during two medicine rounds. We saw they treated people with respect and patience when giving them their medicines. We also saw when a person asked what their medicine was for, the member of senior care staff was able to explain this to them clearly.

We found the home did not have adequate emergency procedures in place. We saw that on the ground floor an emergency exit was locked with a bolt at the top of the door. Staff told us there was always staff working there and that in the event of an evacuation, they would unlock the fire exit. We also saw the exit route was partially obstructed by litter and a fire extinguisher that had been removed from the wall. The registered manager told us that the fire extinguisher had been removed from the wall because of a refurbishment. This meant that there was a risk that people could not leave this area safely because there were obstacles that could slow down an evacuation.

Staff we spoke with did not have a sound understanding of the procedures to follow in an emergency. We asked three staff members about people's individual evacuation plans, particularly for people who would find it difficult to leave the building themselves. They told us they did not know what individual assessments had taken place for people. One care assistant said, "We know from working with people who would manage to leave the building if they heard an alarm but we're not involved in any kind of formal assessment plan." Staff also told us they were not aware of any fire wardens in the home but they would assume the most senior member of staff was in charge in the event of an emergency. We saw an evacuation chair was placed on a landing between two floors of the home. Evacuation chairs are used to help move people down stairs in an emergency. Four out of five members of staff told us that they had not been trained to use the chair and would not know what to do with it. One member of care staff said, "I know the evacuation chair is there but we'd never use it, we've been told that it's up to the fire brigade to help move people." One member of staff told us that they had been trained to use the evacuation chair.

We looked at the home's fire zone plan. This is used for people to understand the layout of the building and to see where fire exits and extinguishers are located. We found the fire zone plan was out of date and did not reflect the changed usage of some rooms or the change in locations of the fire extinguishers. We found the last fire safety

Is the service safe?

inspection had taken place in April 2014. The inspection found the home's safety systems to be "unsatisfactory" in a number of areas. We spoke with the registered manager about this. They showed us an action plan had been implemented to improve fire safety in the home, such as fixing emergency lighting.

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

We found the home was not clean. We observed that 'deep cleans' had not recently taken place. For example, we saw that a rubbish bin in a bathroom was overflowing onto the floor. We also saw that for most of the day of our inspection there was no soap or hand wash in the staff and visitor's toilet. We found that a bath had not been cleaned after use and a thick layer of 'scum' remained in place throughout the day. As we walked around the home we observed items of clothing had been discarded. For instance, underwear had been left under a seat in the lift lobby and in a communal bathroom, a glove had been left behind a seat in a communal lounge and shoes had been left on the floor of a communal landing. This meant people were not always protected from the risk of infection because cleaning procedures were not robust and there was not an effective system to make sure hygiene products were available for use.

During a walk around the home with the registered manager we noticed a strong odour of urine in one area of the home. The registered manager explained the reason for the situation and described the plans to deal with the problem. However, at the time of our inspection these plans had not been progressed. This meant the provider had not taken action to deal with this odour in a timely manner.

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

People we spoke with told us they felt safe living at the home. One person said, "Yes I feel safe. Safe with the staff, I trust them. And safe in the house too, it seems to be very well looked after." Another person said, "I feel very safe here, nothing to worry about." We observed staff took care when supporting people to ensure they were protected from risks. For example, we saw a staff member pushing a person out of the dining room in a wheelchair. As the wheelchair travelled over some small bumps, the member of staff took care to make sure the person was secure in the chair. Staff said, "It's ok [person's name], there's a few bumps, we'll go slowly." We also observed that when a member of staff gave a person a fresh cup of tea they said, "It's quite hot, be careful not to burn your hands." This showed us that staff were aware of people's safety when carrying out routine tasks or activities.

The provider undertook standard assessments to help protect people from a range of potential risks including poor nutrition and moving and handling. Care plans also identified potential risks. For example, one person's 'personal care' care plan identified the person was at risk of poor personal hygiene. However, we found these identified risks were not specific and did not identify the controls needed to manage the risk.

We saw from viewing training records that safeguarding training was up to date. Three members of care staff told us their safeguarding training had helped them to understand how to keep people safe inside the home. We viewed the home's safeguarding log which confirmed safeguarding concerns had been logged, investigated and the outcome of the investigation recorded. The registered manager undertook a three monthly analysis of safeguarding concerns to identify any trends and patterns. For example, for one person where a pattern had been identified 'behaviour charts' had been introduced to identify potential triggers.

All staff we spoke with were able to explain the whistleblowing policy to us. One member of care staff said, "Thankfully I've never had to use it but I wouldn't hesitate, I know how important it is and who it's there to protect."

Repeated sickness amongst some care staff was affecting staffing levels. Staff told us they sometimes felt under pressure. One staff member said, "Staffing is usually fine but some people are very unreliable and there is a high level of sickness." Another staff member said, "If everyone turns up then the shift goes well but we're rushed off our feet because so many people don't turn up." We spoke with the registered manager about this. They said staff sickness had been a problem but they had received support from other homes in the Fourwinds Group. We found the registered manager had implemented an attendance improvement plan to try and address this problem.

We found the registered manager undertook a regular analysis of staffing levels to check the number of staff needed to provide safe levels of care to people. The

Inadequate

Is the service safe?

registered manager told us, and records confirmed, staffing levels were analysed regularly. For example, every Monday and when people were either admitted into or left the home. The outcome of the analysis considered each person's individual care needs against the number of staff hours delivered. This indicated more staff than required were actually being deployed. The registered manager told us the start times for the morning shift had been staggered based on people's dependencies and preferences. However, from our observations during our inspection it was not clear how the findings from the analysis had been implemented. For example, we regularly observed people in the communal lounge were left unsupervised for long periods during the day.

We viewed the home's accident and incident records. There were several people in the home who were at risk of falls and the accident records reflected this. We found incidents and accidents had been logged appropriately.

The provider had recruitment and selection procedures to check new staff were suitable to care for and support vulnerable adults. We viewed the recruitment records for five staff. We found the provider had requested and received references, including one from their most recent employment. A disclosure and barring service (DBS) check had been carried out before confirming any staff appointments. These checks were carried out to ensure people did not have any criminal convictions that may prevent them from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

We saw from viewing the provider's 'Staff Training Matrix' that training the provider considered essential was mostly up to date. This included moving and handling, infection control, fire safety and first aid training. Where updated training was needed this had been planned in advance and dates to deliver this training had been confirmed. Staff told us they felt supported in their caring role. We saw from viewing staff records they were receiving regular supervision and appraisal. This is important so staff have an opportunity to discuss the support, training and development they need to fulfil their caring role. New staff completed an induction programme with more experienced staff supervising them until they were able to work independently.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests.' It also ensures unlawful restrictions are not placed on people in care homes and hospitals. We found the provider was following the requirements of the legislation. We found people had been assessed to establish whether a DoLS authorisation was required. Where required, applications had been submitted to the local authority for approval. The registered manager told us all people where there were doubts about their capacity had DoLS authorisations in place.

Staff had a good understanding of their responsibilities under the MCA. They also had a good understanding of the capacity of the people they provided care to. One member of staff told us about the level of capacity of some people they cared for. We found this information matched the capacity assessment in people's care plans. One staff member said, "Consent to care really depends on the individual. Everyone has a capacity assessment but we know from working with them so closely how likely they are to be able to make a decision on their own." Another staff member said, "We keep a close watch on people's behaviour and capacity. We often see an improvement in people's lucidity and so we work with them to see if they can be more involved in planning their care." Staff told us they had received training in the MCA and DoLS.

We spoke with three care staff about behaviour that challenged the service. They told us some people occasionally had "challenging or aggressive outbursts." One staff member said although they could use some de-escalation techniques to help reassure and calm the person, they had not been formally trained in this and so just had to, "do their best." Another staff member told us they would like some extra training in how to help people with specific complex conditions. This would help them understand the causes of the person's behaviour that challenged the service to enable them to provide appropriate care. We viewed the provider's 'Staff Training Matrix' which provided the dates when training had been completed and future dates for planned training. We saw from viewing the matrix that specific training for managing behaviours that challenge was not included in the matrix. We found that some staff had been trained to recognise the signs of depression in people. A member of staff said, "This was really important training and has definitely been a big help to me. We have some people who are depressed and now I understand how to give them better support."

People gave us mixed views about the meals they were given. One person said, "It's okay I suppose. Breakfast is pretty routine. I like porridge but they never have anything to put in it so it's very plain." Another person said, "The food is delicious, I always look forward to mealtimes." We spoke with three members of care staff about how people were supported to make their own food choices. We were told that staff asked people for their daily meal choices every morning. They said the catering staff were able to accommodate special requests at short notice. There was a visual menu displayed on the wall of the dining room but the pictures of the food options did not match the food that was served.

We observed over the lunch-time to help us understand people's dining experience. We saw there was very little interaction between people and staff. We found staff who were present in the dining room lacked involvement with people. For example, people were served their meals without being told what the food was. The plate was placed in front of them in silence and then the member of staff would leave. This included some people who were confused about their meal and did not know what was on their plate. We also found staff were not attentive to what was happening in the dining room. For example, we saw one person had eaten only two bites of their meal before staff cleared their plate without speaking to them. Staff did

Requires Improvement

Is the service effective?

not ask if there was a problem or if they wanted something else to eat. We saw another person would only eat if a member of staff sat with them. Staff were busy so the person only a few mouthfuls of food when staff had time to assist them. We discussed this with the registered manager who said they were not aware of any complex needs for this person at mealtimes.

We noted during lunchtime people were not supported to have access to appropriate fluids. For example, there were no water jugs on the dining tables. We also saw staff did not pro-actively ask people if they wanted a drink. Water or juice was only given when people requested it. Some people had to ask more than once before they were given a drink. We observed salt, pepper, sauces and other condiments were not freely available on tables. We also saw some dining tables and chairs were dirty. We found people were not supported to sit comfortably or asked where they wanted to sit. One person was seated at a sideways angle to their table and had to stretch some distance to reach their food. One person fell asleep at the dining table after eating. This was not addressed by staff and we noted the person was uncomfortable. This meant appropriate support and attention was not always provided so people had a pleasant dining experience.

People had their healthcare needs met. We found from viewing people's care records that they had regular input from a range of healthcare professionals. This included specialist nurses, community nurses, GPs, dentists, opticians, dietitians and speech and language therapists. We saw people had specific health care plans which gave details about what support they needed with their health related needs. Staff encouraged people to make healthy choices. For example, we observed staff interacted with one person with compassion and humour to encourage them to reduce their smoking intake. They suggested alternative activities rather than spending long periods outside smoking in the garden.

We found improvements were required to ensure the service was appropriate to meet the needs of people living with dementia. The registered manager told us 28 out of 31 residents were living with dementia. We found some adaptation had been made to the home such as additional signage and specific programmes to meet people's personal care needs. However, further work was needed to ensure people received care that met their needs effectively. For example, the registered manager told us the home did not have a dedicated 'dementia champion' (a staff member with specific skills and knowledge of caring for people living with dementia, who acts as a source of information and support for people and staff).

We found people did not have detailed life histories for staff or other professionals to refer to. These are important, especially for people living with dementia, so that staff can better understand the care needs of the people they are looking after. We also found from viewing training records most staff had not completed any specific training in dementia awareness. For example, training records confirmed 22 out of 33 staff members had not completed this training. The registered manager told us people were involved in reminiscence type activities. However, we saw no evidence from our observations, from speaking with people and staff or from viewing care records that meaningful activities specifically for people living with dementia were available for people to take part in.

We recommend the service considers current guidance on caring for people living with dementia and takes action to update their practice accordingly.

Requires Improvement

Is the service caring?

Our findings

We observed that care was not always delivered in such a way as to ensure the welfare and safety of people using the service. On one occasion a person wandered into the lounge. We saw the person drink from a cup left on a table. Despite this being a known risk to the person there were no staff in the communal lounge at that time to supervise people to make sure they were safe. We alerted a staff member who replied, "[Person's name], yeah." On another occasion we observed a person was upset and crying. We again saw there were no staff members present in the lounge to support the person. We alerted the senior care staff on duty that this person was crying. They came into the lounge and activated the 'nurse call' button and left. We saw a staff member entered the lounge and de-activated the 'nurse call' system. The staff member proceeded to ask another person if they would like to be helped out of the lounge. We saw the staff member support them first. They then returned and proceeded to support the person who was crying. This meant people did not always have the support and care they needed to maintain their wellbeing and ensure their safety.

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

People gave us positive feedback about their care. One person said, "It is nice here. The staff are lovely." We spent time observing people in communal areas of the home. We observed there was often a lack of staff in communal lounge areas which meant people were often not supervised and lacked attention from staff for long periods. For example, we found two people had been left to eat porridge without assistance. We saw both people had fallen asleep with spilt porridge on their clothes and on the tables in front of them. We observed staff did not attend to these two people for over 30 minutes. On another occasion we met a person in a hallway who was only wearing a t-shirt and underwear. The person was disoriented and said they could not find their room. They also said they spilled water on their trousers. We could not find any members of staff nearby to help the person and so we activated a 'call bell.' It took over four minutes for a member of staff to attend, during which time the person became agitated and anxious.

We carried out an observation for 50 minutes in the downstairs communal lounge, using the Standard Observation Framework for Inspection (SOFI). We saw at the start of the observation there were nine people and no staff members in the lounge. We also saw there was no TV or background music playing and all nine people were asleep. During our SOFI observation we tracked three people to observe the interactions they experienced and record their 'mood' state throughout the observation period. We saw throughout the observation period the three people received little interaction from staff. For example, staff asked one person if they could hear the TV and then the person received no further interaction for 40 minutes. The other two people received no interaction at all during the 50 minute observation.

We saw that for most of the 50 minutes of our observation there were no staff members in the lounge to supervise people to ensure their safety and welfare. Staff were present in the lounge very briefly on five occasions. For example, a staff member came into the lounge to put a DVD on. On another occasion two staff members supported a person into the lounge. However, on these occasions staff did not initiate interaction with people. Although people were left for long periods when staff did speak with people they did so with patience and without rushing them. In all cases staff spoke clearly and with respect. We observed some occasions when staff adapted their tone of voice and volume of speech effectively to help people. For example, to talk with people and to reassure them, such as when they seemed anxious going to lunch. Another person we spoke with said, "The staff work hard and are very kind. They're very patient and never rush you."

People had access to independent advice and assistance (advocacy) when they needed it. Information about how to access an advocate was displayed in the home. The registered manager told us staff discussed advocacy with people on a one to one basis. The registered manager also confirmed most people living in the home had representation from either an independent advocate or a family member.

Inadequate

Is the service responsive?

Our findings

We found care was not always planned appropriately to meet people's specific needs and ensure their safety and welfare. We viewed a 'behaviour chart' within one person's care records. This identified regular episodes of specific behaviours that challenged the service that the person had displayed. We read this person's 'Capacity and Dementia' care plan. We found this did not contain specific strategies to guide staff to help them provide appropriate support to the person, particularly when they were confused or anxious. For example, the care plan contained generic statements such as to 're-assure when confused.' The capacity and dementia care plan also referred staff to the person's 'behaviour care plan' for additional guidance with managing behaviours that challenged the service. We viewed the person's 'behaviour care plan' and found this did not identify all of the behaviours the person was displaying. We also found the person had been prescribed specific medicines to help staff support them when they were displaying behaviours that challenged the service. We found care plans made no reference to this medicine and did not guide staff as to when and how to administer this medicine appropriately. We also saw the person's care records did not contain a specific risk assessment around supporting and managing the behaviours that challenged the service. This meant the person was not protected against the risks of inappropriate or unsafe care as the provider had failed to plan and deliver care that met their individual needs and ensured their safety and welfare.

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

We spoke with three people about activities. One person said, "Not much goes on around here. Staff are nice but most of the time we just sit." Another person said they were, "Not aware of any activities." Another person said, "Sometimes it can be quite sociable. Especially at mealtimes people can get together and chat." On one occasion a person said, "I am bored stiff." A staff member passing through the lounge at the time said they would, "Turn the TV up a bit." We saw they did not ask the person what they would prefer to do and left with the person turned away from the TV.

We asked staff about the opportunities available for people to take part in activities. They told us the lack of an activities coordinator had meant that activities were difficult to organise and plan. One staff member said, "We've had no activities planner for some time, so the activities programme has completely fallen down. We just don't have time to do activities with people." The registered manager told us a new activities coordinator had been appointed. They said they would be speaking with people to discuss their needs and wishes. We found records of people's daily activities were repetitive in all of the care plans we looked at. For example, for three people the only activity recorded for a two week period was, 'watching TV in lounge.'

Staff said they tried to give people one to one time which included chatting with people and offering emotional support. We did not observe this happening during the day of our inspection. One member of staff said, "If a shift is fully staffed, we get to sit and spend time with people and just talk with them. We know them well and they feel comfortable around us."

Staff had a good awareness of people's needs including their likes and dislikes. They were able to tell us about the people they cared for, such as what they liked to do and how they liked to spend their time. One staff member said they thought it was very important to get to know people so that they felt safe and relaxed living at the home.

We saw each person had a 'pen picture' which included details about them, such as their next of kin and health professionals involved in people's care. The 'pen picture' also included a brief history about the person including information such as their place of birth, previous employment and any interests they had. Care plans included a 'Daily Living' section which included information about people's personal hygiene needs, mobility and dietary intake.

People had their needs assessed when they were admitted into the home. This included identifying 'intended outcomes' from their stay, such as, 'to promote social inclusion.' The assessment was used to develop people's care plans. Care plans identified a clear goal for the person to aim towards and the steps needed to achieve the goal. For example, for one person the goal was to ensure they dressed smartly and were comfortable and happy. This was to be achieved by allowing the person to choose their own clothing, having support from two carers and assistance with brushing their hair.

Inadequate

Is the service responsive?

There were opportunities for people, family members and visiting professionals to give their views about the care provided at the home. The registered manager told us 'residents and relatives' meetings were held until November 2014 but these were not well attended. The registered manager said these had been replaced with one to one meetings. We viewed examples of one to one meeting records. However these were dated prior to November 2014. Items discussed included safeguarding, suggested activities, menus and whether the person was happy and felt able to make suggestions.

We saw there was a system to log and investigate complaints. The complaints log showed that eight complaints had been received. It also showed that these had been investigated and action taken to remedy the situation. For example, this included adjusting staffing levels, on-going observations of particular people. People we spoke with did not raise any specific complaints with us during our inspection.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager. The registered manager had submitted statutory notifications to the Care Quality Commission. Copies of previous notifications were available during our inspection to refer to. The submission of notifications is important to meet the requirements of the law and enable us to monitor any trends or concerns. The registered manager told us the home did not have a specific set of values that underpinned the delivery of care.

People and staff said the home had a good atmosphere. One person said, "The staff are like my extended family, they're so lovely." The registered manager said staff could speak with her whenever they needed to. Staff also confirmed the manager was approachable. One staff member told us, "I know we're short staffed but we're here for the residents and nothing else. The manager supports us brilliantly and her door is always open or she's always on the end of the phone. I've never felt that there's a problem I can't approach her about." Staff had the opportunity to attend team meetings. The registered manager told us these were used to discuss care standards with staff members.

The registered manager told us she regularly observed staff member's care practice whilst walking around the home to ensure people were treated with dignity and respect. The registered manager also told us this was part of the home's ethos and was emphasised from the point of inducting new staff. The registered manager confirmed that she had, "Never heard anything out of hand."

The provider did not have a regular documented system of medicines audits or checks to identify gaps in medication records and ensure they were investigated in a timely manner. We found gaps in signatures on MARs that had not previously been identified and investigated. We discussed our findings with the manager who told us MARs were checked but was unable to provide us with evidence to demonstrate this. We also found no evidence any action had been taken to address the gaps in records.

The quality of care plans was usually checked monthly. We saw these had been done consistently until the end of November 2014 but had not been done since due to staff absences. We checked examples of previous audits and found these had been successful in identifying issues with care plans and ensuring action was taken. For example, checks had identified that one person required additional care plans to be developed. Other people needed particular documents signing to show their consent to receive care.

The registered manager undertook a six monthly quality audit. This included checks on supervision, health and safety, fire safety, care plan updates and staffing levels. The audit also included an analysis of complaints, safeguarding, accidents and incidents. The records showed that action was taken to help prevent incidents happening in the future, such as raising staff awareness of issues at team meetings.

We found the manager had undertaken a regular three monthly analysis of incidents and accidents to identify any trends and patterns. However, the analysis did not include clear learning or directions for staff to try and reduce future accidents. For example, we found accident analyses did not include action plans and that a 'lessons learned' section was not always completed. We noted in one month several people had experienced similar falls and in the 'lessons learned' section of the analysis, "one off incidents" had been recorded. Three consecutive accident analysis reports stated staffing levels had been adjusted to ensure that more staff were available at key times of the day, to make sure there were enough staff to provide safe levels of care during busy times. The accident reports did not indicate if this adjustment had reduced accidents.

People and family members had been sent questionnaires as part of the home's on-going quality assurance programme. We viewed examples of completed questionnaires. These gave mostly positive feedback. For example, one person had commented, "The home is very kind and caring." Another person said they wanted more to read and had been shown where the library was to access a wider variety of books. We saw that a community nurse had given positive feedback about how the registered manager acted on concerns and the staff were keen to learn and take on board on recommendations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who use services and others were not protected against the risks associated infection because of inappropriate standards of cleanliness and hygiene relating to the premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not fully protected against the risks associated with medicines because the provider did not manage medicines appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate emergency procedures.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against the risks of receiving care that is inappropriate or unsafe because care was not planned and delivered to meet their individual needs or ensure their safety and welfare.

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