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Higham House Nursing Home

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

Summary of findings

Overall summary

This comprehensive inspection took place on 13 and 19 March 2018. The first day of our inspection on 13 March was unannounced and the second day on the 19 March 2018 was announced.

At the last comprehensive inspection on 1 March 2017 the service was rated 'Requires Improvement' and was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 9 Person centred care, 11 Need for consent, 12 Safe care and treatment, 13 Safeguarding service users from abuse and improper treatment, 17 Good Governance and 18 Staffing.

Following the last inspection, we asked the provider to complete an action plan to show what they would do, and by when, to improve the key questions under safe, effective and well led, to at least good.

On the 3 May 2017, we carried out a focused inspection that was unannounced. The service was inspected against four of the five questions we ask about services: is the service safe, effective, responsive and well-led. No risks, concerns or significant improvements were identified in the remaining key question: is the service caring through our on-going monitoring or during our inspection activity so we did not inspect this area.

The inspection on 3 May 2017 found that sufficient improvements had been made to meet the breaches in the regulations. The ratings from the previous comprehensive inspection for the key questions inspected were included in calculating the overall rating in the inspection. The rating remained 'Requires Improvement' as we needed to see consistent good practice over time.

At this inspection, we found the good practice improvements found at the last inspection, had not been sustained.

Higham House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Higham House Nursing Home accommodates up to 30 older people in one adapted building. At the time of this inspection, twenty six people were using the service.

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

The provider had not put in place all that was reasonably practicable to maintain the building upkeep, to ensure the premises were safe to use for their intended purpose and used in a safe way.
The provider had not replaced worn and damaged furniture as required to keep the premises and equipment appropriately maintained,

Monitoring systems were not effective to demonstrate accidents and incidents were appropriately analysed to identify hazards, trends or themes, to mitigate the risks of further accidents and incidents.

The provider had not followed local safeguarding protocols. Records did not evidence safeguarding concerns were reported to the relevant authorities. The provider had not taken the necessary action to investigate safeguarding concerns within the timeframe set by the safeguarding authority.

The provider had not always taken timely action to make sure people were protected from the risk of infections, namely the risks of being exposed to Legionella bacteria.

The legal obligation to submit statutory notifications to the Care Quality Commission (CQC) of events and incidents involving people at the service had not been met. Failure to notify CQC of events and safeguarding incidents meant we could not check the provider had taken appropriate action to ensure people's safety and welfare.

Records were not available to demonstrate that feedback received from people using the service and relatives was used to drive continuous improvement at the service.

Staff recruitment records were locked in a cabinet and not made available for inspection. The provider had not taken timely action to have a new lock fitted to the filing cabinet storing the staff files.

People were treated with respect and compassion, although people's privacy and dignity was not always maintained. There was a lack of meaningful activities, as the activity provision at the service was minimal. There was a lack of care and attention to detail when laundering people's clothing and bedding. The laundry systems needed improving to ensure bedding and clothing did not leave the laundry un-ironed and creased.

The staff arrangement did not fully support people's social and emotional needs to be met. Ancillary staffing arrangements, only allowing for basic cleaning to take place, leaving very little time for deep cleaning to take place.
Staff had received training to ensure people's needs were met; this also included training in end of life care.

Medicines were managed appropriately and people received sufficient support to take their medicines as prescribed and when required.

People spoke positively about the staff that supported them and relatives felt staff always made them feel welcome. People and their representatives had opportunities to contribute to the planning of their care and support. People's needs and preferences were set out in their care plans. People's care and support needs were regularly reviewed and updated to ensure information was current to their changing needs.

People were encouraged to eat and drink enough to meet their needs, but the mealtime experience could be improved to make it a more enjoyable and social time for people. Staff monitored and recorded their observations about people's general health and wellbeing and shared this information with all involved in people's care. When they had concerns about people, they took appropriate action so that medical care and attention could be sought promptly from the relevant healthcare professionals.

At this inspection, we found the provider in breach of the legal requirements. You can see what action we told the provider to take with regard to this breach at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The improvements found at the last inspection had not been sustained.

The premises and equipment were not appropriately maintained, and the provider had not replaced worn and damaged furniture as required.

Accidents and incidents were not appropriately analysed to identify hazards, trends or themes, to mitigate the risks of further accidents and incidents. Safeguarding protocols had not been followed. The provider had not taken the necessary action to investigate safeguarding concerns within the timeframe set by the safeguarding authority.

The cabinet containing staff recruitment records was locked The provider had not taken timely action to have a new lock fitted to ensure records were available for inspection.

The staff arrangement did not fully support people's social and emotional needs. The cleaning staff had little time available to enable deep cleaning to take place.

People received sufficient support to take their medicines as prescribed and when required.

Is the service effective?

Requires Improvement

The service was not always effective.

People expressed some dissatisfaction regarding the meal provision. The dining experience for people needed further work to improve.

Staff monitored people's food and drink intake to ensure people ate and drank sufficient amounts.

Healthcare professionals were contacted and their advice was sought in response to people's changing needs.

The nursing and care staff received induction training and on-going refresher training in line with current best practice guidance. Systems were in place for staff to receive supervision.

Staff had received training to working in line with the Mental Capacity Act 2005 and the Deprivation of liberty safeguards.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always upheld.

People's personal clothing and bedding was not always laundered with care and attention. Resulting in some people wearing creased clothing and sleeping in beds with creased sheets.

People spoke positively about staff. The staff treated people with kindness and compassion. Relatives said staff always made them feel welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and relatives did not always feel they were fully involved in the care planning process.

Further work was needed to support people to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them, including in the wider community.

The care plans contained sufficient information to inform the staff on people's physical, mental, emotional and social needs.

People knew how to make any complaints and as such felt confident to speak directly to the registered manager if they felt they needed to make a complaint.

Is the service well-led?

Inadequate

The service was not well–led.

The improvements identified at the last inspection had not been sustained and embedded.

The quality assurance systems and processes were not effective

in identifying and mitigating risks to ensure people were protected from harm.
No formal process was in place to demonstrate the provider had oversight of the management of the service.

The provider had not taken appropriate action in response to feedback from people using the service to make improvements at the service.

The provider had not carried out their legal obligation to submit statutory notifications to the Care Quality Commission (CQC) of deaths, events and other incidents.

Higham House Nursing 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.

The inspection took place over two days. The first day on 13 March 2018 was unannounced and the second day of inspection on the 19 March 2018 was announced.

On the 13 March 2018, the inspection team consisted of a lead inspector, an inspection manager, a specialist nurse advisor and an expert by experience. The specialist nurse advisor had experience of clinical governance systems. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Two inspectors conducted the announced inspection on the 19 March 2018.

Before the inspection, we reviewed information we held about the service. We also reviewed information the provider had sent us in the Provider Information Return (PIR). The PIR information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also looked at reports from previous inspections and statutory notifications submitted by the provider. Statutory notifications contain information the provider is required to send us by law about significant events that take place within the service. We also received feedback from commissioners that placed people to live at the service.

During our inspection, we spoke with 11 people using the service and five visiting relatives. We spoke to the registered manager, two registered nurses, a senior care worker, three care staff, two catering staff, a domestic worker and the activity person.

We looked at five people's care records, the medicines administration records (MAR), two staff recruitment files and records that were available of quality audits carried out at the service.

We undertook general observations throughout our visit and we used the short observational framework for inspection (SOFI) leading up to and during lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At the comprehensive inspection carried out in March 2017 the service was rated Requires Improvement and in breach of Regulation 12 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In May 2017, a focused inspection found improvements had been made and the breaches had been met, but the rating remained requires improvement, as we needed to see consistent good practice over time.

At this inspection, we found the improvements to maintain good practice had not been sustained. The provider was unable to demonstrate lessons learned to improve safety across the service.

The staff confirmed they had received safeguarding training and training records evidenced this. However, effective management systems and processes were not followed to respond to and investigate safeguarding concerns. We contacted the registered manager on the 15 March to request safeguarding records be made available for review at the announced inspection on 19 March 2018. However, at the inspection the registered manager told us that all safeguarding records prior to 2018 had been archived and they were unable to access them.

On the 5 February 2018, the Local Safeguarding Authority (LSA) informed the Care Quality Commission (CQC) that they had received a safeguarding concern regarding the care of a person using the service. They asked the registered manager to carry out an investigation into the concern and respond with their investigation within 28 days. At the inspection, no safeguarding records prior to and from 2018 were available for review. The lack of records meant we were unable to verify the actions taken by the registered manager in response to safeguarding concerns brought to their attention.

Following our inspection the LSA informed CQC that no response had been received from the registered manager to the initial request made on 5 February 2018 and a further request made on 27 March 2018. This meant the registered manager had not co-operated with the LSA in responding to alleged abuse and had failed to act by carry out an investigation.

Systems were not effective to demonstrate that accidents and incidents were analysed to identify, trends or themes. The registered manager told us they had archived all accident and incident records prior to January 2018. Records of accidents and incidents, during January and February 2018, indicated that nursing staff had treated people for minor injuries, such as skin tears that had mainly been sustained from falls. The registered manager said they analysed accident and incident records, however no audit records were available to evidence what actions had been taken to mitigate the risks of repeat incidents and protect people from further harm.

The provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

The provider had not put in place all that was reasonably practicable to ensure the premises at Higham House Nursing Home were safe to use for their intended purpose and used in a safe way. The service provided care for people living with dementia and at times with heightened confusion. On the first day of the inspection we found bedrooms on the first floor had windows that opened wide enough for vulnerable people to fall out and be harmed. The window frames were not robust enough to withstand foreseeable force to open the window further, or withstand damage (either deliberate or from general wear). The windows did not have secure tamper-proof window restrictor fittings to prevent them from being disengaged without the use of a special opening tool or key. In four bedrooms, we found window frame handles were broken and some windows did not close properly, this exposed people to draughts, which may have caused discomfort and potential illness.

The patio door leading to the garden was unable to be locked and only prevented from being opened by the use of a strip of wood placed in the doorframe. This presented risks to people who may have tried to access the door and was not an adequate safety or security measure to prevent the door from being opened from outside.

Following a fire protection officer's visit to Higham House Nursing Home in June 2016, a recommendation was made that all doors were checked to ensure they had intumescent strips/cold smoke seals in place, and they were intact. At this inspection, we found bedroom doors that did not have intumescent strips/cold smoke seals fitted. In the event of a fire, this could have placed people's lives at risk. We also found poorly maintained door closures, and fire doors fitted with 'hold-open' devices (that should automatically close in response to the sound of the fire alarm), being held open with wedges. This put people at risk in the event of a fire.

We also found the fire exit door leading out of the laundry was obstructed with linen skips. This meant in the event of a fire people would not have been able to use this exit route. In addition, we noted that three bedrooms were numbered 'room 2', which in the event of the service requiring full evacuation had the potential to cause confusion and delay evacuation.

The registered manager said they carried out weekly fire alarm system checks. However, they had archived all records relating to tests carried out prior to January 2018. The only records available for inspection were of tests carried out on 4, 12 and 25 January 2018 and the 1st and 9 February 2018. The records did not verify that weekly fire alarm system tests took place as confirmed, as no tests had been recorded over a five week period. The fire risk assessment and personal evacuation plans were not made available for inspection. However, following the inspection the registered manager confirmed theses records were in place, and a fire protection officer that visited the service following our inspection, also confirmed the records were in place.

Staff said they received fire safety training and the training records confirmed this. However, a record of a fire drill carried out on the 23 January 2018, listed the registered manager and six staff responded to the fire alarm being activated. However, the staff rota for the same day showed that two of the staff listed as attending the drill were on sick leave and three staff listed were on their days off. The registered manager said they had mistakenly put the wrong date on the form, this meant the fire drill records could not be relied upon.

Following our inspection, we contacted the Fire Safety Officer (FSO) to inform them of our findings. The FSO carried out a follow up visit and made further recommendations for the provider to take immediate action. The provider was told to check all fire-resisting doors from bedrooms and rooms leading onto the means of escape to ensure they were all fitted with intumescent strips, cold smoke seals and self-closing devices. The FSO stressed to the provider to check that doors fitted with door closing devices that respond to the sound

of the fire alarm must not be wedged open. The provider was also advised to ensure that all fire exits were clear of obstructions and available to use at all times. They advised that given the discrepancies in the fire drill record that more detailed reports of fire drills were needed.

The provider had not always taken timely action to make sure people were protected from the risk of infections, namely the risks of being exposed to Legionella bacteria. On the 3 January 2018, the registered manager and an external contractor had completed a legionella risk assessment. The risk assessment identified that disused pipework throughout the service required removing. The registered manager confirmed the showers within the en-suite facilities were not used because the cubicles were too small and not suitable for people with limited mobility to access. We saw that some of the control measures and actions as identified in the legionella risk assessment had been carried out, such as the flushing of disused taps and showers. However, the registered manager confirmed that action was still required to take place to remove the disused pipework throughout the building.

The registered manager could not access records of audits carried out prior to up to 2018 as they said these records had been archived. This meant we were unable to verify water checks had been consistently undertaken.

The provider had not taken timely action to address food safety requirements. A food safety visit by an Environmental Health Officer (EHO) took place in December 2017 and the service was issued with four Food Safety Requirements. The timescale given to meet the requirements was one month. We found that two of the requirements had not been met. These included the fitting of a suitable extractor hood to provide sufficient ventilation in the main kitchen area and the replacement or repair of rusted under counter shelving. Following the inspection, we contacted the EHO to discuss our findings and they carried out a visit to follow up on their recommendations.

The majority of people using the service did not have leads connected to the nurse call system. Two people that did have call leads connected told us the staff responded to them. One person said, "They [staff] usually come within 10 minutes." The other person said, "They [staff] do their best, sometimes they are busy with someone but they always do come." One person being cared for in bed did not have a nurse call lead connected to the system, another person also being cared for in bed did have a nurse call lead available, however the lead was out of their reach.

The registered manager said most people using the service did not know how to use the call bells and for some people with heightened confusion, having a call bell lead could present hazardous. However, the rational for making such decisions had not been formulated through the risk assessment process, taking into consideration choice and capacity. These people were isolated in their bedrooms with not means to summon staff assistance other than calling out. In addition, no system was in place for specific safety and well-being checks to be undertaken, other than when staff attended to provide personal care and give food and drinks.

The provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Staff told us they had received training on infection control and staff training records confirmed this. We observed that staff used personal protective equipment (PPE) to reduce the risk of spreading and contaminating people with infectious diseases. However, the environment would have benefited from a thorough deep cleaning. For example, we found dried on food debris around the kitchen serving hatch, dirt and dust around skirting boards. Some mattresses, walking frames and wheelchair frames were stained,

armchairs, especially recliner chairs had ripped upholstery with the filler exposed and stained.

Many of the profile bedframes and bedrail bumpers were badly scuffed and worn; one person's bedframe was coming apart at the end of the bed. This was brought to the attention of the registered manager during the inspection and they arranged for a temporary repair to be made. These bedframes and bumpers did not allow for proper cleaning and disinfection.

The equipment cleaning records had several gaps where staff had not maintained records of cleaning tasks. There was a lack of evidence to demonstrate the monitoring of the environment and the cleaning / disinfection records to check the premises and equipment were being cleaned in accordance with the cleaning schedules.

The bedroom numbers that displayed on the nurse call system did not always match the numbers on bedroom doors, for example, three bedroom doors were all numbered room 2. One staff member said, "When I first started working here I found it very confusing, but I have got used to it now." The duplicating of bedroom numbers had caused confusion for staff; it had the potential to delay staff when responding to the nurse call system and to place the safety of people at risk.

The provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

We contacted the registered manager on the 15 March 2018 to request staff recruitment records be made available for review at the announced inspection on 19 March 2018. However, at the inspection, we were unable to access all staff recruitment records. The registered manager told us the key to the filing cabinet containing the records had been stolen. We asked the registered manager to arrange for the filing cabinet to be opened and have a new lock fitted.

The registered manager was unable to meet our request and provided us with two staff recruitment files to view (that had not been stored in the filing cabinet). The files were in relation to one member of staff employed in 2008 and another in 2016. As we did not have access to staff records we were unable to verify the quality of the staff recruitment practices, the arrangements to support staff, disciplinary procedures, and on-going staff checks.

Following our inspection, we were informed by commissioners that during an announced quality monitoring visit in December 2017 they had also been unable to access staff recruitment files for the same reason and had been given the same two staff recruitment files to view. This meant the provider had not ensured that information was available for inspection by regulators and commissioners in relation to each member of staff employed at the service.

People received sufficient support to take their medicines as prescribed and when required. One person said, "They [Staff] always bring my medicines on time, (this person was prescribed medicines, which needed to be administered at a specific time). A relative said, "I know they [Staff] are good with pain relief because [Name of person] used to get very agitated at the previous care home they lived at, I knew it was pain related, but that doesn't happen now, so I know they are doing it right." The care records contained information regarding how people preferred to receive their medicines. The staff kept appropriate records in relation to the receipt, administration and disposal of medicines. We saw that medicines were stored safely and securely. Nursing staff had their competency to safely administer medicines reviewed and assessed.

The care as described in people's care records identified individual risks to people's health and welfare. For

example, one person found personal care difficult to accept, their risk assessment explained how staff needed to approach the person to cause the least distress and to respect their wishes as to how they wanted their personal care to be delivered.

At the last inspection in May 2017, we were informed the provider had put in place a formal dependency tool to ensure numbers of staff remained suitable to meet the needs of people using the service. However, at this inspection we did not see the dependency tool was being used and we were unable to verify how staffing ratios were determined. People and relatives spoke of staff always being busy. One person said, "I always see a carer, but they are really busy." Another person said, "The carers are nice but they don't have much time to chat." A third person said, "There is always someone available but they [staff] are very busy."

A staff member said, "I love my job, I find the best time to have a conversation with people is when I am assisting someone to have a bath. This is a good time to have a one to one conversation." These comments indicated at times, the staff arrangement did not fully support people's social and emotional needs. Ancillary staffing arrangements, only allowed for basic cleaning to take place, leaving little time for deep cleaning to take place.

Requires Improvement

Is the service effective?

Our findings

At the comprehensive inspection carried out in March 2017 the service was rated Requires Improvement and in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

In May 2017, a focused inspection found that although improvements had been made to meet the breaches in relation to Regulation 11 the rating remained requires improvement, as we needed to see consistent good practice over time.

At this inspection, we found the improvements had not been sustained to consistently provide effective care.

People said the meals were okay. One person said, "I don't feel hungry, the food is okay, but sometimes it's luke warm, I know I can send it back, but you don't really do you?" Another person said, "There's not much choice, you just have what they give you, I suppose if you asked you might get something different, but no one really does." Another person said, "Breakfast used to be served at 8am, lunch just after 12 and a snack supper at 4pm but now it is usually up to an hour later."

We observed people receiving the lunchtime meal, we noted all people were served their meals on picnic style plastic plates and drinks were served in the same style plastic cups and beakers. The registered manager said, they once had a problem with a person throwing plates, but this no longer happened, but the practice continued. They acknowledged, the blanket approach of everybody using plastic plates, cups and glasses was unacceptable and unless assessed a risk, they said they would ensure all people had their meals served using suitable crockery plates, cups and glassware.

In the dining room, we noted there was little interaction between the staff serving people their meals, apart from one member of staff who spoke with people, explaining what the meal consisted of when assisting them to eat their meal. One staff member stood behind a person when placing their food on the table in front of them, the staff member said nothing to the person and walked away. One person did not eat much of their main meal; the staff left the plate on the table and gave them their dessert. However, when the person finished their dessert a staff member put the dinner plate back in front of them and tried to persuade the person to finish eating their dinner, by which time it was cold.

During the mealtime, the staff were busy; several people needed help with cutting up their food but by the time the staff got to them their food was chilling. One person sat with a plate of food in front of them for 40 minutes and was struggling to eat their meal. It was only when the dining room was almost empty that staff noticed the person had not eaten their meal. Assistance was offered to the person to eat their meal, but by which time the meal was cold. The person said they only wanted their dessert and asked for ice cream, but staff offered fruit salad, this was pointed out to a staff member, who then gave the person ice cream. Staff confirmed that on the day of the inspection the person was not feeling well and did not feel like eating.

During the mealtime, one person was calling out that they could not see their food and wanted to wear their glasses. However, staff did not respond immediately to the person's request, one member of staff offered reassurance to the person after the mealtime was over. We enquired with staff whether the person did wear glasses, and received conflicting information. One member of staff said the person did not wear glasses, whilst two other staff said the person did and they did not know where they were. One member of staff said the person often called out during the meal times saying, "[Name of person] does this all the time." This did not demonstrate all staff knew about the person and understood how to respond appropriately to their complex needs.

We did observe some good interactions by staff providing people with support to eat and drink within one of the lounges. The staff were seated beside people; they explained what was for the meal. They gave people time to eat and drink and engaged in conversation with the people they were supporting.

The environment did not promote freedom of movement and there was no facility for people to meet with visitors in private other than in bedrooms.

The door leading to the annex was locked and stair gates were in use, this restricted people's freedom to independently move around the building. The risk assessments for the locked door and stair gates outlined they were used to prevent people from entering other people's bedrooms. We saw that relatives had signed the risk assessments. Close Circuit Television (CCTV) was also in operation within the communal areas of building; however, no signage was displayed to inform people and visitors of its use. People being under surveillance posed the question as to whether the use of physical restrictions to people's movement was a proportionate approach to keeping people safe.

Staff recorded what people ate and drank. They used this information along with nutritional risk assessments to check that people were eating and drinking enough. Any concerns about people's food and fluid intake, had been brought to the attention of the GP and nutritional support was sought from relevant healthcare professionals. We saw that people identified at nutritional risk had food supplement drinks prescribed and people with swallowing problems had thickener prescribed to add to drinks.

People's care, treatment and support was delivered in line with their assessed needs and preferences. One relative said, "[Name of person] is well cared for here, the staff know how to communicate with [Name of person], the staff here know how to respond to [Name of person] they are much more settled here than in their previous care home." Another relative said, "This home was recommended to us, [Name of person] likes it here."

We found people's care plans had sufficient information available to inform staff on the level of support people required to keep healthy. The staff worked with other healthcare professionals such as the GP, the district nurse, the tissue viability nurse and the community psychiatric nurse to ensure people's specific healthcare needs were effectively met. Relatives told us they were aware their family members had visits from other healthcare professionals and they were informed of any changes in their family member's health.

One person said, "The GP visits once a week, but if you are ill then they will come out." Another person said, "If you want to see the doctor then you can ask, but we have a nurse here too." A third person said, "The optician visits, there was one came here a short while ago and I had an appointment." Relatives confirmed that staff kept them informed of changes in their family member's health. One relative said, "They [staff] will always phone me if [Name of person] has a fall, but if they are unwell they just wait for me to come in."

Staff told us they received sufficient training and records evidenced this. The training included induction training and on-going refresher training to keep staffs knowledge and skills up to date. The nursing staff were provided with relevant training to keep their clinical competence up to date, and the care staff completed training that was relevant to their roles.

Staff told us they felt supported in their roles and that supervision meetings took place, approximately every three months, when they had the opportunity to discuss their work and personal development needs. Staff told us that general team meetings did not take place very often; the registered manager also confirmed this. The staff said that each day they had the opportunity to meet and discuss changes in people's needs during shift handovers.

Capacity assessments had taken place to assess people's ability to make choices and consent to their care and support. During the inspection, we observed staff prompt people to make choices and decisions and sought permission from people before providing any support.

We checked whether the service was continuing to work within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA.

Staff endeavoured to involve people's relatives or representatives and relevant healthcare professionals in making decisions in people's best interests, where people lacked the capacity to make informed decisions. The registered manager had submitted DoLS applications to deprive people of their liberty, to the local authority, however they were still awaiting authorisations to by the appropriate body to be made. The registered manager was advised to regularly review the DoLS applications to check that they were still relevant and appropriate.

Requires Improvement

Is the service caring?

Our findings

People's privacy and dignity was not always maintained. We observed occasions when staff entered people's bedrooms without knocking, or introducing themselves or waiting to be invited in. We saw on a number of occasions a person was sat on the toilet in the main corridor with the door open in full view. The registered manager and staff said the person refused to have the door shut, however due to limited space when using a walking frame; the door was also unable to close.

We suggested whether staff could encourage the person to use the toilet in the adjacent bathroom, but the registered manager explained the person refused to use this facility. We discussed other options as to how staff could try to preserve the person's dignity, such as using a curtain or portable screen at the door, or asking the person if they wanted a member of staff to stay with them, so the door could be closed.

The main shower room used at the service did not have any privacy screening at the window. In one person's bedroom, called the 'salon bedroom', no curtains or blind were up at one of the windows. The ensuite was used as a storage area for the hairdressing equipment, the room was cluttered and unusable. No record was available within the persons care plan to confirm they had been consulted and consented to having the equipment stored in their ensuite facility.

The responses from people in answer to how staff treated them indicated they were generally pleased with care they received. One person said, "The carers are mostly good, but they are very busy." Another person said, "The carers are nice and some are really helpful." A third person said, "Some of them [staff] are really good, but some are okay."

We observed interactions between people using the service and staff. Some staff naturally responded to people, smiling, saying hello, asking how they were feeling and stopping to chat, whilst some staff did not respond as well. This was particularly noticeable in the 'seaside themed' lounge that was a thoroughfare to the annex part of the building, with staff regularly walking through the room. We observed one person tried to get the attention of staff each time they walked passed them, some staff noticed this and took the time to stop and speak with the person, whilst some walked passed without acknowledging the persons attempts to speak to them. Another person also tried to speak with staff but their voice was very weak and they resorted to pointing to the staff but their attempts to get the staff attention was not acknowledged.

Personal clothing and bedding was not always laundered with due care and attention. This had resulted in some people wearing clothes that were very creased and to sleeping on bedding that was very creased.

The provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

We observed two staff members provided reassurance to a person using a hoist to transfer them from their armchair into a wheelchair. The staff took time to explain to the person what they needed to do to move them safely, and did not start the move until the person understood and was ready to move. During the

move, they spoke with the person all the time to reassure them. However, we also saw two staff assisting another person to move using the hoist and they did not communicate very much with the person apart from, 'put your hands here' from beginning to end.

Some people chose to spend most of their time in their rooms. One person said they chose to because they felt anxious and preferred to be on their own, they said their family members visited most days. One person had their cat living with them, the person said, "I am very grateful to the home manager for allowing me to bring my cat with me, there is not many places who would take me and my cat, it's really important to me."

Information was available on advocacy services. Advocacy services represent people where there is no one independent, such as a family member or friend to represent them. The registered manager confirmed at the time of the inspection no people were currently using an advocacy service, but people had previously.

Requires Improvement

Is the service responsive?

Our findings

At the comprehensive inspection carried out in March 2017 the service was rated 'Requires Improvement' and in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person Centred Care. This was because people's care plans needed to be more detailed.

In May 2017, a focused inspection found the care plans were more detailed and the breach had been met, but the rating remained requires improvement, as we needed to see consistent good practice over time.

At this inspection, we found further work was needed to improve the service.

Further work was needed to support people to follow their interests and take part in meaningful activities that were socially and culturally relevant and appropriate to them, including in the wider community. An activity person was employed by the service; however, the activity person also worked as a care worker and confirmed they often spent more time working as a carer than as the activity person. They said they enjoyed providing activities and found it frustrating when taken off this role to work as a carer.

We observed one person entered the front lounge room and went to sit down and a staff member quickly stopped the person saying "That is someone's private chair you can't sit there." All the other armchairs were taken being used and the person had to sit in a dining chair.
During the afternoon, the television was on, but people were not engaged in the programme that was on. A member of staff suggested to the people in the room, whether they would like to watch the horse racing, to which people said they did. People seemed to be enjoying watching the racing, but soon after some visitors arrived, to visit their relative that was sitting in the lounge. Unfortunately due to the limited space the visitors had to sit in the middle of the room opposite their relative, which blocked the view of the TV for some people. In addition, the volume of the TV was loud, and the visitors had to raise their voices in order to be heard by their relative. This was a little overwhelming for the people in the room, as they were unable to enjoy the racing uninterrupted.

This highlighted the need for the service to have a facility available for visitors to meet with their relatives in private. One person sat in the dining room with a word search book, they said, "It's better than being on my own in my room and this is a bright room." The dining room had a bright outlook over the garden and was mainly unused apart from mealtimes.

One relative said the staff had arranged a party for their 50th Wedding Anniversary. They said, "The staff arranged a lovely little gathering for our anniversary, it was really nice."

The registered manager told us that outside entertainers, such as singers and musicians visited the service and more recently an aromatherapist had started visiting provide massage therapy. They said they were looking for an appropriate activity course for the activity person to undertake to increase their knowledge and skills to provide suitable activities for people living with dementia.

We saw that photos were on display of activities that had taken place during the summer in the garden and of cake decorating activities.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. There was no evidence to demonstrate how the provider had looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. For example, how they met the communication needs of people with sensory loss. How they shared information with others when required, and how they gained people's consent to do so.

There was a complaints policy. The registered manager told us they had not received any complaints over the past twelve months. People and relatives told us they would speak directly to the registered manager if they felt they needed to make a complaint. One relative said, "I don't have to make a complaint, I can just raise an issue and someone will help." Another relative said, "I would just speak to the manager." One relative said they had attended a relatives meeting but they were the only one that attended, they said, "I was the only one there, so really it really wasn't much of a meeting."

The care plans had sufficient information on people's physical, mental, emotional and social needs. Assessments identified areas requiring nursing intervention. People at risk of developing pressure ulcers had appropriate pressure relieving equipment in place and the care plans detailed the pressure care required. Staff checked the settings of pressure mattress on a daily basis to ensure they were consistently set at the correct pressure for the person using the equipment. The registered nurses regularly reviewed the care plans to ensure they remained current and reflected changing needs.

People using the service or those with authority to act on their behalf, were invited to contribute to the assessment and care planning processes. However, some of the comments we received indicated people and relatives did not always feel they were involved in the care planning process. For example, one person said, "If they [staff] don't volunteer to tell me about my care, I ask and they answer me because I make sure they do." One relative said, "I have not been involved in [Name of person's] care plan, and have never had a meeting to sit down and discuss [Name of person's] care."

The nursing and care staff received end of life training to ensure people would receive support at the end of their life that was comfortable and dignified. At the time of the inspection, no people were receiving end of life care.

Inadequate

Is the service well-led?

Our findings

At the comprehensive inspection carried out in March 2017 the service was rated Requires Improvement and in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the systems or processes to assess monitor and improve the quality and safety of the service had not consistently been implemented effectively.

In May 2017, a focused inspection found that although improvements had been made to meet the breach in Regulation 17, however the rating remained requires improvement, as we needed to see consistent good practice over time.

At this inspection, we found the improvements to maintain good practice had not been sustained.

There was a lack of oversight by the provider on checking the day-to-day management of the service. There was a lack of leadership of the service when the registered manager was not on duty. This had placed people at risk as no senior member of staff took on the responsibility of managing the staff to oversee the care and treatment of people using the service.

The registered manager informed us that all records in relation to quality checks and management audits undertaken prior to 2018 had been archived. The only management records available to review were records from 1st January 2018. This meant we were unable to verify the actions taken by the registered manager in continually assessing the quality of the service. The provider did not undertake any formal reviews of the service and there was little or no evidence of learning, or reflective practice to drive service improvement.

Systems and processes were not effective in identifying and responding to environmental risks, such as ineffective window restrictors, damaged window frames, fire hazards and infection control hazards. The quality checks that had been undertaken had not identified environmental risk factors and poor maintenance of the premises and equipment.
Systems and processes were not effective in responding to accidents and incidents. There was little or no evidence to show what action had been taken to mitigate the risks of further accidents and incidents. Accidents and incidents that fell within the scope of safeguarding had not been reported to CQC or the safeguarding authority.

The provider had not taken appropriate action in response to feedback from people using the service. A satisfaction survey carried out in April 2017 identified areas for improvement, such as, the need for more activities, concerns raised about people wearing other people's clothing, poor hygiene and odours. No action plan had been put in place to demonstrate how the provider used this feedback to drive improvement of the service.

Timely action had not been taken to ensure staff records were available for inspection by regulators and commissioners. We were therefore unable to verify the quality of staff recruitment practices, the

arrangements to support staff, disciplinary procedures, and on-going staff checks.

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

The provider had not carried out the legal obligation to submit statutory notifications to the Care Quality Commission (CQC) of deaths, other events and serious incidents. The last notification received by CQC from the provider was on the 9 February 2017.

In June 2017, CQC received concerns that the service had no hot water or cooker. We contacted the registered manager to discuss the concerns. The registered manager confirmed they did have problems with the boiler and the cooker, and they were in the process of being repaired. We advised the registered manager to submit a notification of 'events that stop the service' to CQC detailing the actions they had taken, however, no notification was received by CQC.

The accident and incident records seen at the time of the inspection showed that some people had sustained unexplained injuries, such as bruising and skin tears. Such incidents should have constituted safeguarding alerts to be made to the Local Safeguarding Authority (LSA) and also notifying to CQC. Failure to notify CQC of events and safeguarding incidents meant we could not check the provider had taken appropriate action to ensure people's safety and welfare.

This was in breach of Regulation 16 and 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

People and staff spoke positively about the registered manager and staff. The people and relatives spoken with, all knew who the registered manager was. One relative said, "I can speak to [Name of registered manager] or any of the nurses, they will all listen." Another relative said, "I know the manager and if I was worried I would speak to her or to [Name of nurse]."

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had the rating on display in the front entrance of the service.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's rights to privacy and dignity was not always upheld.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding incidents had not always been reported to the relevant authorities.

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 16 Registration Regulations 2009 Notification of death of a person who uses services The provider had failed to notify CQC of all deaths at the service.

The enforcement action we took:

Fixed penalty notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not carried out the legal obligation to submit statutory notifications to the Care Quality Commission (CQC) of deaths, events and other incidents.

The enforcement action we took:

Fixed Penalty Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practicable to ensure the premises were safe to use for their intended purpose and used in a safe way.

The enforcement action we took:

Notice of Proposal to impose a condition on registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not taken timely action to make sure people were protected from the risk of health related infections.

The enforcement action we took:

NoP to impose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not undertake any formal reviews of the service to reflect on practice and identify areas requiring improvement.

The enforcement action we took:

NoP to impose a condition.